DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

December 30, 2024

The President
The White House
Washington, DC 20500

Dear Mr. President:

I am pleased to submit the enclosed Report to Congress for Fiscal Year (FY) 2019 as required by the Older Americans Act (OAA) of 1965, as amended. This report provides specific information requested in the OAA, including statistical data reflecting services and activities provided to individuals, and evaluative assessments of programs performed by the National Aging Services Network authorized in the Act.

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In FY 2019, AoA and the aging network rendered direct services to over 10.5 million individuals aged 60 and over (one out of every seven older adults), including over three million clients who received intensive in-home services. Critical supports, such as respite care and a peer support network, were provided to over 837,000 caregivers.

I hope you will find the report informative.

Sincerely,

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Enclosure

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DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

December 30, 2024

The Honorable Mike Johnson
Speaker
United States House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

I am pleased to submit the enclosed Report to Congress for Fiscal Year (FY) 2019 as required by the Older Americans Act (OAA) of 1965, as amended. This report provides specific information requested in the OAA, including statistical data reflecting services and activities provided to individuals, and evaluative assessments of programs performed by the National Aging Services Network authorized in the Act.

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DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY
Assistant Secretary for Legislation
Washington, DC 20201

December 30, 2024

The Honorable Bill Cassidy, M.D.
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, DC 20510

Dear Senator Cassidy:

I am pleased to submit the enclosed Report to Congress for Fiscal Year (FY) 2019 as required by the Older Americans Act (OAA) of 1965, as amended. This report provides specific information requested in the OAA, including statistical data reflecting services and activities provided to individuals, and evaluative assessments of programs performed by the National Aging Services Network authorized in the Act.

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DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY
Assistant Secretary for Legislation
Washington, DC 20201

December 30, 2024

The Honorable Mike Braun
Ranking Member
Special Committee on Aging
United States Senate
Washington, DC 20510

Dear Senator Braun:

I am pleased to submit the enclosed Report to Congress for Fiscal Year (FY) 2019 as required by the Older Americans Act (OAA) of 1965, as amended. This report provides specific information requested in the OAA, including statistical data reflecting services and activities provided to individuals, and evaluative assessments of programs performed by the National Aging Services Network authorized in the Act.

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DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

December 30, 2024

The Honorable Denis McDonough
Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary McDonough:

I am pleased to submit the enclosed Report to Congress for Fiscal Year (FY) 2019 as required by the Older Americans Act (OAA) of 1965, as amended. This report provides specific information requested in the OAA, including statistical data reflecting services and activities provided to individuals, and evaluative assessments of programs performed by the National Aging Services Network authorized in the Act.

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DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

December 30, 2024

The Honorable Virginia Foxx
Chairwoman
Committee on Education and the Workforce
United States House of Representatives
Washington, DC 20515

Dear Chair Foxx:

I am pleased to submit the enclosed Report to Congress for Fiscal Year (FY) 2019 as required by the Older Americans Act (OAA) of 1965, as amended. This report provides specific information requested in the OAA, including statistical data reflecting services and activities provided to individuals, and evaluative assessments of programs performed by the National Aging Services Network authorized in the Act.

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DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

December 30, 2024

The Honorable Kamala D. Harris
Vice President of the United States
President
United States Senate
Washington, DC 20510

Dear Madam Vice President:

I am pleased to submit the enclosed Report to Congress for Fiscal Year (FY) 2019 as required by the Older Americans Act (OAA) of 1965, as amended. This report provides specific information requested in the OAA, including statistical data reflecting services and activities provided to individuals, and evaluative assessments of programs performed by the National Aging Services Network authorized in the Act.

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DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

December 30, 2024

The Honorable Bernie Sanders
Chairperson
Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, DC 20510

Dear Chair Sanders:

I am pleased to submit the enclosed Report to Congress for Fiscal Year (FY) 2019 as required by the Older Americans Act (OAA) of 1965, as amended. This report provides specific information requested in the OAA, including statistical data reflecting services and activities provided to individuals, and evaluative assessments of programs performed by the National Aging Services Network authorized in the Act.

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DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY
Assistant Secretary for Legislation
Washington, DC 20201

December 30, 2024

The Honorable Robert P. Casey, Jr.
Chairperson
Special Committee on Aging
United States Senate
Washington, DC 20510

Dear Chair Casey:

I am pleased to submit the enclosed Report to Congress for Fiscal Year (FY) 2019 as required by the Older Americans Act (OAA) of 1965, as amended. This report provides specific information requested in the OAA, including statistical data reflecting services and activities provided to individuals, and evaluative assessments of programs performed by the National Aging Services Network authorized in the Act.

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DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

December 30, 2024

The Honorable Robert C. "Bobby" Scott
Ranking Member
Committee on Education and the Workforce
United States House of Representatives
Washington, DC 20515

Dear Representative Scott:

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DEPARTMENT of HEALTH and HUMAN SERVICES

FY 2019 Older Americans Act Report to Congress

Prepared by
ADMINISTRATION ON AGING

ADMINISTRATION FOR COMMUNITY LIVING

Table of Contents

Table of Contents

INTRODUCTION **1**
PART I: HEALTH AND INDEPENDENCE **6**
Home and Community-Based Supportive Services 7
Nutrition Services 9
Preventive Health Services 15
Chronic Disease Self-Management Education Programs 17
Behavioral Health 20
Falls Prevention Programs 21
Caregiver Services 23
National Family Caregiver Support Program 24
Brain Health 26
Alzheimer's Disease Programs Initiative (ADPI) 27
PART II: OLDER AMERICAN INDIANS, ALASKA NATIVES, & NATIVE HAWAIIANS **29**
Nutrition and Supportive Services 29
Caregiver Support Services 30
PART III: ELDER RIGHTS **32**
Prevention of Elder Abuse and Neglect 33
National Center on Law and Elder Rights 35
Legal Assistance Enhancement Programs (LAEP) 36
Pension Counseling and Information Program 37
Long-Term Care Ombudsman Program 40
Aging and Disability Resource Centers/No Wrong Door System 44
Aging Network Support Activities 46
Appendix **50**
Formula Grant Funding Allocations 50
by State, Territory, and Tribal Organization 50

INTRODUCTION

The Administration for Community Living exists to make it possible for older adults and people with disabilities to live and participate fully in their communities. Community living is an exceptional value – people overwhelmingly prefer it to living in institutions, it is usually less expensive than institutional care, and it results in better health. To that end, ACL funds services and supports provided primarily by networks of community-based organizations, and invests in research, training, and innovation to make that principle a reality for millions of people.
As part of this important mission, ACL's Administration on Aging (AoA) implements a wide range of programs and services authorized under the Older Americans Act (OAA).

Since 1965, OAA programs have successfully provided critical services that have better enabled millions of older Americans to live independently, with dignity, in their homes and communities. Congress passed the OAA in 1965 in response to concern by policymakers about a lack of community social services for older people. It established authority for grants to states for community planning and social services, research and development projects, and personnel training in the field of aging. The law also established the aging services network – a national network of federal, state, and local agencies to plan and provide services to help older adults live independently. AoA was created as the head of that network, to administer the newly created grant programs and to serve as the federal focal point on matters concerning older people. Although older adults may receive services under many other federal programs, today the OAA is recognized as the primary national mechanism for the organization and delivery of social and nutrition services to this group and their caregivers. It authorizes a wide array of health and health-related social services programs through a national aging services network made up of state agencies on aging, area agencies on aging, tribal organizations, and thousands of service providers in communities across the nation.

In FY 2019, the aging services network included 56 state and territorial units on aging, 629 area agencies on aging, 270 Indian tribal and Native Hawaiian organizations, more than 20,000 direct service providers, and hundreds of thousands of volunteers. Through the network, OAA services reached one in seven older Americans, helping them maintain their health and independence, primarily in their own homes and communities. These services include home-delivered and congregate meals, support for family caregivers, preventive health services, personal and home care services, transportation, legal assistance, and elder abuse prevention. The OAA also includes community service employment for low-income older Americans and training, research, and demonstration activities in the field of aging. Many of the services are adapted to meet the needs of Native American elders and their caregivers. In addition, the OAA provides ombudsman services for people who live in long-term care facilities. The OAA also includes community service employment for low-income older Americans and training, research, and demonstration activities in the field of aging.

OAA programs are successful because they are flexible and focus on the needs of each person, better ensuring that their rights, choices, needs, and independence are maintained through their input and participation. Because of the OAA, neighborhoods, tribes, and other organizations across the country can continue to draw upon the wealth of knowledge that comes only with life experience in remaining at home for as long as possible, promote the rights of older adults, and advocate for people who live in long-term care facilities (nursing homes, board and care, assisted living, and similar settings).

While many of the programs have evolved since the passage of the OAA in 1965, one thing has not changed over time. Older adults overwhelmingly want to continue to live independently, in the community – and nearly 95 percent of them do.

Aging presents much to celebrate, as older adults contribute to their families and communities through providing wisdom, perspective, life experience, and other resources. Yet people can also need support as they grow older with health and daily living challenges. The national aging services network is uniquely prepared to meet the challenges of an aging population and celebrate the myriad ways older adults benefit their communities and the nation. Through the OAA, the national aging services network is providing high-quality services to more older adults and their caregivers than ever before and doing so in a cost-effective manner. In FY 2019, as a direct result of OAA services and programs, more than 10 million older adults received services that helped them live in their own homes and fully participate in their communities, including nutritious meals, chronic disease self-management and falls prevention. Their caregivers received training, respite care and other services so they could provide quality care for longer. And the OAA's elder justice programs provided protections from scams, abuse, and other harms. Without these vital programs, more older adults would require far more expensive care in nursing homes and other facilities, and communities and families across the nation would lack the rich opportunities for connection, learning, and intergenerational relationships that are made possible only through community living.

Overview of FY 2019 Performance

By statute, OAA program activities have a shared fundamental purpose: to develop and support a comprehensive, coordinated, and cost-effective system of long-term services and supports that help older adults and maintain their health and independence in their homes and communities. To that end, AoA established following four performance goals:

1. Providing high quality services that result in positive consumer outcomes and reflect effective delivery systems.
2. Effectively targeting services to at-risk populations.
3. Improving program efficiency.
4. Promoting rights and preventing abuse of older adults.

Each performance goal reflects activities spanning across OAA programs, which address distinct issues and populations. AoA intentionally collects and reports information on a program-by-program basis to ensure that the results of programs that serve smaller numbers of people (e.g., chore services and adult day care) are not overwhelmed by the results of programs that serve much larger populations (e.g., nutrition services) and to ensure that the unique elements of the varied programs can be highlighted. Progress toward achievement is tracked using several performance measures. Taken together, the performance goals and their corresponding metrics are designed to reflect AoA's goals and objectives and in turn measure success in accomplishing AoA's mission.

Performance Highlights

Analysis of AoA's program performance trends through FY 2019 illustrates that AoA programs continue to help individuals remain independent and in the community – in a prudent and cost-effective manner. In FY 2019, they provided essential services and information to millions of older Americans and their caregivers, with a particular emphasis on older adults in greatest economic and greatest social need, as required by the OAA. For example:

- AoA and the national aging services network provided direct services to over 10.5 million people age 60 and over.
    - Over 7,800 people were served with each million dollars of OAA Title III funding.
- More than 24,000 older adults participated in evidence based chronic disease self-management programs.
- Two-thirds of all OAA services were delivered to people in underserved populations including those living in rural areas.
- In keeping with the provisions of the OAA, a third of all services were delivered to older adults with the greatest social need and greatest economic need.
- Over three million people who received OAA services required intensive in-home services such as assistance with eating, dressing, and bathing.[1]
- OAA programs also supported over 800,000 family caregivers to enable them to continue to provide care to loved ones. These included services such as respite care, training, and a peer support network.[2]
- American Indian, Alaska Native, and Native Hawaiian elders received over 762,852 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical activities and more than 800,000 hours of outreach and informational services thereby empowering them to make informed choices about their care needs and well-being. [3][4]
- More than 22,000 homebound Native American elders received meals from providers and volunteers who also provided critical social connections that help to reduce the risk of depression and isolation experienced by many home-bound Native American elders.[5]
- Another 65,000 Native American elders received more than 2.6 million meals in community-based settings, providing them an opportunity to socialize and participate in a variety of activities, including cultural and wellness programs.[6]
- Long-term care ombudsman programs nationwide completed resolution work on 198,502 complaints and resolved 71.5 percent of these complaints to the full or partial satisfaction of the resident or complainant.[7]

The tables below provide a summary of the people served during FY 2019 through the OAA's programs. Additionally, a listing of grant funding allocations by state, territory, and tribal organization can be viewed in the Appendix.

---

[1] AoA's FY 2019 State Program Report.
[2] Ibid.
[3] ACL's OAA Title VI Program Performance Report, PY 2019.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] FFY 2019 National Ombudsman Reporting System (NORS) is the source for this and other data in this section. States report NORS data annually to ACL.

FY 2019 National Program Data on Services Provided

Total Clients	10,856,053
Total Registered Clients	2,735,229
Percent Minority Clients[8]	32.70%
Percent Rural Clients	34.15%
Percent Clients Below Poverty	33.40%
Number of Senior Centers	10,185 (6,075 received OAA funding)

Service	**Persons Served**	**Units of Service**[9]	**Title III Expenditure**	**Total Expenditure**
Personal Care	126,311	26,680,068	$65,913,967	$438,162,567
Homemaker	176,224	21,851,479	$35,963,024	$436,915,357
Chore	29,734	759,641	$4,989,681	$19,565,086
Home Delivered Meals	883,586	149,974,193	$345,620,340	$972,259,016
Adult Day Care	19,877	12,108,163	$12,997,961	$110,582,663
Case Management	472,750	3,339,861	$106,712,284	$277,516,647
Assisted Transportation	55,363	2,472,710	$5,696,370	$35,970,366
Congregate Meals	1,508,422	73,337,377	$317,813,934	$671,642,284
Nutrition Counseling	22,739	33,351	$972,870	$2,514,430
Transportation		20,435,668	$65,035,657	$205,928,259
Legal Assistance		964,837	$30,221,524	$55,027,663
Nutrition Education		3,318,154	$3,420,791	$7,208,975
Information and Assistance		12,474,836	$58,922,221	$191,156,627
Outreach		1,995,990	$9,834,025	$21,871,545
Health Promotion and Disease Prevention	605,729		$27,188,657	$64,320,303
Self-Directed Care	13,051		$512,535	$105,416,421
Other Services	12,975,70		$79,451,084	$694,300,823

[8] Minority client refers to individuals who self-report at least one of the following racial or ethnic identities: Asian, Black, or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islanders, American Indian, or Alaska Native.

[9] Service Units Definitions:

Personal Care = 1 hour
Homemaker = 1 hour
Chore = 1 Hour
Home-Delivered Meal = 1 meal.
Adult Day Care/Adult Day Health = 1 hour
Case Management = 1 hour
Assisted Transportation = 1 one-way trip
Congregate Meal = 1 meal
Nutrition Counseling = 1 session per participant
Transportation = 1 one-way trip
Legal Assistance = 1 hour
Nutrition Education = 1 session per participant
Information and Assistance = 1 contact

National Family Caregiver Support Program

Service	Caregivers Served	Service Units[10]	Title III Expenditure	Total Expenditure
Counseling/Support Groups/Caregiver Training	107,468	518,452	$21,413,984	$32,644,389
Respite	61,030	6,407,292	$60,432,366	$99,012,250
Supplemental Services	28,622		$12,918,970	$16,885,435
Self-Directed Care	1,809		$1,181,958	$1,476,518
Access Assistance	563,731	1,382,397	$36,431,293	$54,370,944
Information Services	24,878,682	1,070,993	$12,548,990	$19,696,761
Unduplicated Caregivers Provided Service or Access	800,722			

[10] Title III-E service units' definitions:
Counseling = 1 session per participant
Respite Care = 1 hour
Supplemental services = variable
Access Assistance = 1 contact
Self-Directed = variable
Information Services = 1 activity

PART I: HEALTH AND INDEPENDENCE

The OAA's Health and Independence for Older Adults programs provide an interconnected foundation of services that help older people remain healthy and independent in their homes and communities, avoiding expensive institutional care. These programs include Home and Community-Based Supportive Services, Senior Nutrition Programs (which provides meals served in congregate settings, as well as home-delivered meals), Preventive Health Services, Chronic Disease Self-Management, Behavioral Health, Falls Prevention, Caregiver Services (including the National Family Caregiver Support Program), Brain Health, and the Alzheimers Disease Programs Initiative.

Today, Americans are living longer and more active lives. This is due, in part, to advances in public health and medical care. The average life expectancy of an American has increased dramatically over the last century, from 50.9 years in 1917 to 78.8 years in 2019[11,12] and more older adults than ever before are living with chronic health conditions for which they may need multiple forms of assistance to maintain their independence and quality of life.

The programs made possible by the OAA make a crucial difference in the lives of the people they serve. 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.
In 2019, OAA programs assisted over 10.8 million older adults and their caregivers.[13] These services were especially critical for the nearly three million older adults who received intensive in-home services, more than 511,000 of whom met the disability criteria for nursing home admission.[14] These services provided an important benefit to the nation's taxpayers because they help to keep these individuals from joining the 1.7 million older adult residents who live for extended periods of time in nursing homes.[15]

Sixty-seven percent of congregate and 88 percent of home-delivered meal recipients reported that the meals help them to continue living in their own home and 54 percent of older adults using transportation services rely on them for most of their trips to doctors' offices, pharmacies, meal sites, and other critical daily activities that help them to remain in the community.[16]

Considering limited long-term care coverage under Medicare and constrictions in the long-term care insurance market, many Americans with few resources will continue to rely on Medicaid to furnish their long-term care. Supporting less costly community-based options is a critical function of government and will continue to be an important tool in managing federal expenditures. AoA programs provide the foundation necessary to support these changing demographic realities.

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[11] Arias E, Xu JQ. United States life tables, 2019.National Vital Statistics Reports; vol 70 no 19. Hyattsville, MD: National Center for Health Statistics. 2022. Accessed on November 14, 2022, at https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-08-508.pdf

[12] Ibid.

[13] AoA's FY 2019 State Program Report.

[14] Ibid.

[15] Centers for Medicare & Medicaid Services, ACL analysis of 2017 Medicare Current Beneficiary Survey. Accessed on November 14, 2022, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/.

[16] 2019 National Survey of Older Americans Act Participants. Accessed on November 16, 2022, at http://www.agid.acl.gov.

OAA programs such as Nutrition Services, Chronic Disease Self-Management, Falls Prevention, and others also bring the potential to reduce health care expenses for the nation. Data shows that over 92 percent of older Americans have at least one chronic condition and approximately three-fourths have at least two.[17] Medicare beneficiaries with multiple chronic conditions are the heaviest users of health care services. For example, two-thirds of Medicare beneficiaries have two or more chronic conditions and account for 94 percent of Medicare spending, and those with four or more chronic conditions account for 78 percent or three-fourths of Medicare spending.[18] Among Medicare beneficiaries age 65 and over who are not dually eligible (enrolled in both Medicare and Medicaid), standardized Medicare per capita spending increases from $5,440 for persons with two to three chronic conditions to $27,883 for persons with six or more chronic conditions.[19] Among Medicare beneficiaries age 65 and over who are dually eligible, standardized Medicare per capita spending increases from $6,092 for persons with two to three conditions to $32,662 for persons with six or more chronic conditions.[20]

In addition to these benefits to the nation, OAA programs also provide an efficient use of federal resources while delivering essential support to the nation's elders. Federal support for OAA programs is not expected to cover the cost of serving every older American. These programs have strong partnerships with state and local governments, philanthropic organizations, and private donations that also contribute funding. States typically leverage resources of between two and three dollars per every federal OAA dollar, significantly exceeding the programs' match requirements.

Home and Community-Based Supportive Services

(Title III-B of OAA; FY 2019: $385,074,000)

The OAA's Home and Community-Based Supportive Services (HCBSS) program, established in 1973, provides grants to states and territories based on their share of the population age 60 and over. The HCBSS program includes a broad array of services and serves older adults holistically. While each HCBSS service is valuable in and of itself, it is often the combination of supports, when tailored to the needs of the individual that help older persons remain in their own homes and communities instead of entering nursing homes or other types of facilities.[21]

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

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[17] Ibid.

[18] CMS Chronic Conditions Charts: 2018. Figure 13: Distribution of Medicare Fee-for-Service Beneficiaries and Medicare Spending by Number of Chronic Conditions: 2018. Accessed on November 14, 2022 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.html

[19] CMS Multiple Chronic Conditions Utilization/Spending State Level: All Beneficiaries by Medicare-Medicaid Enrollment and Age, 2007-2017. Accessed on November 14, 2022, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/MCC_Main

[20] Ibid.

[21] Brock, D et al. "Risk Factors for Nursing Home Placement among OAA Service Recipients: Summary Analysis from Five Data Sources" Westat; U.S. Administration on Aging Contract No. 233-02-0087. Accessed on November 14, 2022, at https://acl.gov/sites/default/files/common/Risk_Factors.pdf f.

While age alone does not determine the need for these services, statistics show that both disability rates and the use of long-term services and supports increase with advancing age. Among those aged 85 and older, 48 percent are unable to perform critical activities of daily living, such as bathing and eating, and require long-term support.[22] Providing a variety of supportive services that meet the diverse needs of these older individuals is crucial to enabling them to remain healthy and independent in their homes and communities, and therefore to avoiding unnecessary, expensive nursing home care that is often publicly financed.

Services provided by the HCBSS program in FY 2019 include:[23]

- Transportation Services provided 20.4 million rides to doctors' offices, grocery stores, pharmacies, senior centers, meal sites, and other critical daily activities.
- Personal Care, Homemaker, and Chore Services provided nearly 49.3 million hours of assistance to older adults unable to perform activities of daily living (such as eating, dressing, or bathing) or instrumental activities of daily living (such as shopping or light housework).
- Adult Day Care/Day Health provided 12.1 million hours of care for program participants in a group setting that provides health, therapeutic, and social services, and activities during some portion of a twenty-four-hour day.
- Case Management Services provided over 3.3 million hours of assistance in assessing needs, developing care plans, and arranging services for older persons or their caregivers.

Data from AoA's National Survey of Older Americans Act Participants show that HCBSS are providing older adults with the assistance and information they report help them to remain at home.[24] For example, over 82 percent of clients receiving case management reported that because of the services arranged by the case manager, they were better able to care for themselves.[25]

Reflecting the OAA's requirement to target services to those in greatest social need and greatest economic need, nearly 46 percent of riders on OAA-funded transportation do not own a car or, if they do own a car, they do not drive and are not near public transportation.[26] Many of these individuals cannot safely drive a car, as nearly 70 percent of transportation riders have at least one of the following chronic conditions that could impair their ability to navigate safely:[27]

- 3.1 percent have Parkinson's disease.
- 1.5 percent have multiple sclerosis.
- 4.3 percent have epilepsy.
- 6.3 percent have Alzheimer's disease or dementia.
- 19.5 percent have had a stroke.
- 66.5 percent of riders had a doctor tell them they had vision problems (including glaucoma, macular degeneration, or cataracts).

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[22] Centers for Medicare & Medicaid Services, ACL analysis of 2017 Medicare Current Beneficiary Survey. Accessed on November 14, 2022, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/.
[23] AoA's FY 2019 State Program Report.
[24] Ibid.
[25] Ibid.
[26] 2019 National Survey of Older Americans Act Participants. Accessed on November 14, 2022, at https://agid.acl.gov
[27] Ibid

- 69.9 percent have arthritis.

Living alone is a key predictor of nursing home admission, and HCBSS are critical for enabling individuals to remain at home, especially for those who do not have an informal caregiver to assist with their care. Nationally, 24 percent of individuals 60 and older live alone.[28] OAA programs serve a disproportionate number of people who live alone compared to the general population.[29] Research has also shown that childless older adults who live in a state with higher home and community-based services expenditures had significantly lower risk of nursing home admissions.[30]

Nutrition Services

Nutrition Services help older adults remain healthy and independent in their communities by providing nutritious meals, nutritional screening, education, nutrition counseling, and other services, (e.g., food boxes, supplements). The Congregate Nutrition Services Program (NSP) is offered in a variety of settings (such as senior centers, public housing locations, local libraries, farmer's markets, religious buildings, or community centers). The Home-Delivered NSP provides in-home meals and related services to older adults who are unable to participate in the congregate program due to illness, disability, or geographic isolation. OAA Nutrition Services Programs include:

Congregate Nutrition Services Program *(Title III-C1; FY 2019: $495,342,000):* Provides funding for the provision of nutritious meals, nutrition education, screening, and counseling in a variety of congregate settings, which helps keep older adults healthy and may decrease or prevent the need for more costly medical interventions. Established in 1972, the program centers around serving nutritious meals, but it also presents opportunities for social engagement, health and wellness activities, and meaningful volunteer roles, all of which contribute to overall health and well-being. Ninety-three percent of congregate meal participants were socially active and were satisfied with their opportunities to spend time with other people.[31] The typical congregate meal participant does not experience loneliness and only seven percent of congregate meal participants screened positively for depression.[32]

Home-Delivered Nutrition Services Program (*Title III-C2; FY 2019: $251,342,000*): Provides funding for the delivery of nutritious meals and nutrition-related services. Home-Delivered NSPs provide opportunities for social engagement and, in many cases, an informal 'safety check.' Eighty-one percent of home delivered meal participants reported being somewhat satisfied or very satisfied with their opportunities to spend time with other people, and 19 percent screened positively for depression.[33]
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.

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[28] American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2019). Accessed on November 16, 2022, at https://www.agid.acl.gov.
[29] 2018 2019 and National Survey of Older Americans Act Participants. Accessed on November 16, 2022, at http://agid.acl.gov.
[30] Muramatsu, Naoko. "Risk of Nursing Home Admission Among Older Americans: Does States' Spending on Home and Community-Based Services Matter?" May 2007. Journal of Gerontology: Psychological Sciences. Accessed on November 16, 2022, at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2093949/.
[31] Evaluation of the Effect of the Older Americans Act Title III-C Nutrition Services Program on Participants' Food Security, Socialization, and Diet Quality 2017. Accessed on November 14, 2022, at https://acl.gov/sites/default/files/programs/2017-07/AoA_outcomesevaluation_final.pdf.
[32] Ibid.
[33] Ibid.

Home-delivered meals are a key element in helping older adults, who may not be able to prepare their own meals, remain in the community.

Nutrition Services Incentive Program *(Title III-A; FY 2019: $160,069,000):* Provides additional funding to states, territories, and eligible tribal organizations to be used exclusively to procure food products for use in the Title III- C-1 and C-2 and Title VI meal programs. This funding 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 receive grants as a cash allocation and/or purchase USDA Foods (previously referred to as commodities) directly from the U.S. Department of Agriculture (USDA) with any portion of their award if they determine that doing so will enable them to better meet the needs of older adults. In FY 2019, six states and two tribes elected to take some portion of the allotment in USDA Foods.

The meals provided through these programs must fulfill the standards set by the current Dietary Guidelines for Americans and provide a minimum of 33 percent of the Dietary Reference Intakes, as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.[34] Meals also comply with applicable provisions of state and local food safety codes. The nutrition-related services provided through these programs may also include nutrition education, nutrition counseling, and other nutrition services, as appropriate, based on the needs of NSP participants.

Nutrition Service Programs help over 2.4 million older adults receive the meals they need to stay healthy and decrease their risk of disability.[35] Because the prevalence of multiple chronic conditions is higher among congregate and home-delivered program participants than for the general Medicare population, the provision of healthy meals, access to lifestyle modification programs, and evidence-based advice such as nutrition education and counseling are important. Data from AoA's 2019 National Survey of Older Americans Act Participants indicate that 43 percent of congregate and 64 percent of home-delivered participants have six or more chronic conditions. About 30 percent of congregate and 55 percent of home-delivered participants take more than six medications per day, and some take as many as 20 medications.[36] The congregate and home-delivered NSP participants are significantly less healthy than the general Medicare population and access to adequate healthy meals is essential to their well-being. Additionally, the nutrition service programs generally serve older and more frail older adults than the general Medicare population, as they have a demonstrated need for healthy, prepared meals, rather than just access to food.[37] For these reasons, meals are an important element in supporting independence of older adults and may contribute to the deferral or delay of institutional placement.

The OAA Nutrition Service Programs target services to older adults in greatest social and greatest economic need, including those individuals who experience food insecurity. Approximately 40 percent of home-delivered and 20 percent of congregate clients reported it was often or sometimes true that the food they bought just did not last and they did not have

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[34] Home | Dietary Guidelines for Americans and Dietary Reference Intakes | Food and Nutrition Information Center | NAL | USDA

[35] AoA's FY 2019 State Program Report.

[36] 2019 National Survey of Older Americans Act Participants. Accessed on November 14, 2022, at http://agid.acl.gov.

[37] Ibid, and U.S. Census Bureau, Population Estimates, 2019. https://www.census.gov/data/tables/time-series/demo/popest/2010s-national-detail.html Accessed on November 16, 2022.

money to get more food (low food security); 45 percent of home-delivered and 24 percent of congregate clients reported it was often or sometimes true that they did not have enough money/food stamps to buy food (low food security); and 20 percent of home-delivered and 11 percent of congregate clients indicate they had to skip a meal because they did not have money/food stamps to buy food (very low food security).[38] The data also indicate that 16 percent of congregate and 78 percent of home-delivered participants have difficulty getting outside the house, thus limiting their ability to shop for food themselves.[39] The number of home-delivered meal recipients with severe disabilities (difficulty performing three or more activities of daily living) totaled over 360,000 in FY 2019.[40] This level of disability is frequently associated with nursing home admission, and demonstrates the vital role of home-delivered meals in supporting older adults living in community settings.

Research has indicated that living alone often increases an older adult's risk of inadequate social connections, which may exacerbate social isolation. Social isolation is associated with high health risks. Individuals who lack social connections or report frequent feelings of loneliness tend to suffer higher rates of morbidity, infection, depression, and cognitive decline.[41] The number of older adults that live alone is higher for program participants vis-a-vis the public. Nationally, 24 percent of adults aged 60 or over live alone.[42] However, through effective targeting, 43 percent of congregate NSP participants and 58 percent of home NSP participants live alone.[43] In a 2017 national evaluation, when nonparticipants were compared to participants in the congregate meal program, participants were more satisfied with their socialization.[44]

The NSP serves nutritious meals to older adults to improve or maintain the participant's health status, avoid hunger and malnutrition, and improve the participant's food security status. Older adults that do not have reliable access to enough affordable, nutritious food are considered food insecure. A 2017 evaluation of the OAA nutrition services programs on participant's food security, socialization and diet quality showed that lower-income older adults who participated in the congregate meal program were significantly less food insecure than nonparticipants (23.2 versus 31.0 percent).[45]

Food insecure older adults are 65 percent more likely to be diabetic, 2.3 times more likely to suffer from depression, 57 percent more likely to have congestive heart failure, 66 percent more likely to have experienced a heart attack, twice as likely to report having gum disease, and 91 percent more likely to have asthma.[46]

Data from AoA's 2019 National Survey of Older Americans Act Participants show that NSP are effectively helping older adults improve their nutritional intake and remain at home. For example, 71 percent of congregate and 83 percent of home-delivered meal participants stated the

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[38] 2019 National Survey of Older Americans Act Participants. Accessed on November 16, 2022, at http://agid.acl.gov/.
[39] Ibid.
[40] AoA's FY 2019 State Program Report.
[41] https://www.cdc.gov/aging/publications/features/lonely-older-adults.html
[42] 2019 National Survey of Older Americans Act Participants. Accessed on November 16, 2022, at http://agid.acl.gov.
[43] 2018 National Survey of Older Americans Act Participants. Accessed on November 14, 2022, at http://www.agid.acl.gov.
[44] Mabli, J. et al. (2017). Evaluation of the Effect of the Older Americans Act Title III-C Nutrition Services Program on Participants' Food Security, Socialization, and Diet Quality, April 21, 2017. Accessed on November 14, 2022, at https://acl.gov/sites/default/files/programs/2017-07/AoA_outcomesevaluation_final.pdf
[45] Ibid.
[46] Gundersen, C., & Ziliak, J. (2017). The Health Consequences of Senior Hunger in the United States: Evidence from the 1999–2014 NHANES. Prepared for Feeding America and the National Foundation to End Senior Hunger.

program had helped them to eat healthier foods and 67 percent of congregate and 88 percent of home-delivered meal participants, reported the program had helped them to remain in their own home. Independent research has found that states that invest more in delivering OAA home-delivered meals to older adults' have lower rates of "low-care" older adults in nursing homes after adjusting for several other factors.[47] For every $25 per year per older adult that states spend on home-delivered meals, the state reduces their percentage of these lower needs nursing home residents by one percent when compared to the national average.[48] This evidence is a testimonial to the savings gained from this foundational home- and community-based service.

AoA's annual performance data further demonstrate that these programs are highly valued by older people who need assistance to remain healthy and independent in their homes. More than 90 percent of home-delivered meal clients and 89 percent of congregate participants rate the meal as good to excellent.[49] According to a 2017 evaluation, congregate NSP participant's diets provided more nutrient dense foods and nutrients when compared to nonparticipants. Congregate NSP participants had significantly higher intake percentages of dairy (69 vs 72), total fruit (97 vs 72) and total vegetables (87 vs 60). Home NSP participants consumed a significantly higher percentage of dairy when compared to nonparticipants (72 vs 58). The most recent data show these nutrition programs are helping older adults remain healthy and independent in their homes.[50]

- Home-Delivered Nutrition Services provided 150 million meals to over 883,000 individuals in FY 2019.[51]
- Congregate Nutrition Services provided over 73.6 million meals to more than 1.5 million older adults in a variety of community settings in FY 2019.[52]

Consistent with the OAA's requirement to target services to those with the greatest social or economic need, approximately 39 percent of congregate meal recipients and 67 percent of home-delivered meal recipients have annual incomes at or below $20,000.[53] Meals are especially critical for the 61 percent of home-delivered and 55 percent of congregate recipients who report these meals provide half or more of their food intake for the day.[54]

Federal support for the NSP is not expected to provide all needed funding for all programs, nor provide programming for every older adult. These programs have strong partnerships with state and local governments, philanthropic organizations and private donations that contribute funding. In FY 2019, state and local funding comprised 71 percent of all the funding for home-delivered meals and congregate meals, leveraging more state and local financial support than many other OAA programs.[55]

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[47] Thomas, K & Moe, V. The relationship between Older Americans Act Title III State Expenditures & Prevalence of Low-Care Nursing Home Residents. Health Services Research. 12.3.12. Accessed March 23, 2018, at: http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12015/abstract
[48] Ibid.
[49] 2019 National Survey of Older Americans Act Participants. Accessed on November 16, 2022, at http://www.agid.acl.gov.
[50] Mabli, J. et al. (2017). Evaluation of the Effect of the Older Americans Act Title III-C Nutrition Services Program on Participants' Food Security, Socialization, and Diet Quality, April 21, 2017. Accessed on November 14, 2022, at https://acl.gov/sites/default/files/programs/2017-07/AoA_outcomesevaluation_final.pdf.
[51] AoA's FY 2019 State Program Report.
[52] Ibid.
[53] 2019 National Survey of Older Americans Act Participants. Accessed on November 14, 2022, at http://www.agid.acl.gov.
[54] Ibid.
[55] AoA's FY 2019 State Program Report.

Beginning in FY 2017, Congress authorized ACL to use up to 1 percent of the funds appropriated to ACL's nutrition programs to develop, pilot, or replicate innovative, evidence-informed practices for the NSP.

In FY 2019, ACL awarded seven Innovations in Nutrition (INNU) research grants, totaling $3,400,308. Through these three-year project grants, ACL sought to increase collective knowledge about effective interventions to achieve the goals of the OAA NSPs and translate the knowledge generated by these projects into evidence-based models for delivering nutrition program services and programs at the community level. FY 2019 INNU grantees' project areas emphasized:

- Increased business and programmatic skills for congregate meal providers and area agencies on aging.
- Streamlined access for healthcare providers to connect clients to home delivered meal services.
- Improved nutrition status, including medical meals adherence, decreased food insecurity, and an increase in nutritional quality measures, among older adults receiving nutritional support; and
- Increased participation in congregate meal programs.

State and Territory Flexibility

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

The OAA provides states the flexibility necessary to meet the nutritional needs of older adults. This flexibility is important to meet the needs identified in communities and allows them to respond quickly to changing needs when natural disasters occur. For example, the OAA allows a state to transfer up to 40 percent of the funds between congregate and home-delivered meals (nutrition services) for use as the state considers appropriate to meet the needs of the area served. Additionally, for any fiscal year in which the transferred funds are insufficient to satisfy the need for nutrition services, the Assistant Secretary for Aging may grant a waiver that permits the state to transfer an additional 10 percent of the funds to meet those needs. The OAA provides further flexibility to states by allowing them to transfer up to 30 percent for any fiscal year between supportive services programs and nutrition services programs, for use as the state considers appropriate. Further, for any fiscal year in which the transferred funds are insufficient to satisfy the need for supportive services and nutrition services, the Assistant Secretary for Aging may grant a waiver that permits the state to transfer an additional amount of funds to meet those needs. Transfer are options open only to states and territories. A state agency may not delegate to an area agency on aging or any other entity the authority to make such transfers. The table below outlines the transfers of Federal funds within Title III of the OAA for FY 19.

FY 2019 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	$382,367,856	$489,550,292	$248,444,380
Final Allotment after Transfers	$439,050,548	$380,709,041	$300,602,939
Net Transfer	$56,682,692	($108,841,251)	$52,158,559
Net Percent Change	**14.82%**	**(-22.23%)**	**20.99%**

Preventive Health Services
(Title III-D of OAA; FY 2019: $24,848,000)

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

Starting in 2012 and continuing every year since, ACL's appropriations language has specified that funds from OAA Title III-D can be used "only for disease prevention and health promotion programs and activities which have been demonstrated through rigorous evaluation to be evidence-based and effective." Since 2012, all Preventative Health Services funding has been used for the delivery of evidence-based programs for older adults across the nation. States have the flexibility to determine the program(s) they offer, based on state and local needs, preferences, and resources. Programs can be delivered in a variety of formats, such as in-person (group or one-on-one), virtual (videoconference), by phone, via mailed toolkit, or a combination of these things (hybrid). States have the option of funding other health services, such as blood pressure screenings, using OAA funding for supportive services (Title III-B).

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

- Physical activity: Maintaining (or increasing) physical activity is a necessary component for staying healthy. There are several evidence-based programs focused on empowering older adults to stay or become active through strength training, cardiovascular workouts, balance exercises, and more.

- Falls prevention: Falls prevention programs help older adult participants improve strength, balance, and mobility; provide education on how to avoid falls, and reduce fall risk factors; and some involve medication reviews and provide home assessments of ways to reduce environmental hazards.
- Medication management: Medication management programs focus on reviewing the multitude of medications that older adults are prescribed, focusing especially on high-risk medications. Medication management programs have been shown to reduce unnecessary duplication of prescriptions and cardiovascular problems.[56] These programs have also been shown to improve medication usage rates and decrease medication errors among older adults.[57]
- Depression care management: Depression is not a normal part of aging, yet it is a prevalent and disabling condition among older adults. In 2017, 15 percent of Medicare Fee-for-Service Beneficiaries age 65 and older had a depression diagnosis.[58] Depression in older adults has been associated with high direct medical costs (i.e., hospitalizations), as well as significant indirect costs (i.e., unpaid caregiving).[59] Cost-effective, evidence-based interventions, such as the Program to Encourage Rewarding Lives for Seniors (PEARLS), developed in CDC's Prevention Research Centers, have been shown to reduce depressive symptoms and improve quality of life in older adults.[60]

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[56] Meredith, S., Feldman, P., Frey, D., Giammarco, L., Hall, K., Arnold, K., Ray, W. A. (2002). Improving medication use in newly admitted home healthcare patients: A randomized controlled trial. Journal of the American Geriatrics Society, 50(9), 1484–1491. PubMed abstract available at http://www.ncbi.nlm.nih.gov/pubmed/12383144. Accessed March 23, 2018.

[57] A summary of these studies can be found at: https://www.acl.gov/programs/strengthening-aging-and-disability-networks/aging-and-disability-evidence-based-programs

[58] CMS Chartbook and Charts. Figure 2: Prevalence of Chronic Conditions among Fee-for-Service Beneficiaries by Age: 2017. Chronic Condition Charts: 2017. Accessed May 15, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.html.

[55] Snow, C.E.; Abrams, R.C. The Indirect Costs of Late-Life Depression in the United States: A Literature Review and Perspective. *Geriatrics* 2016, *1*, 30.

[60] Program to Encourage Rewarding Lives for Seniors (2012). Description available at: http://www.pearlsprogram.org/

Chronic Disease Self-Management Education Programs
(FY 2019: $8,000,000)

In the United States, approximately three of four older adults have (two or more chronic conditions, such as diabetes, arthritis, heart disease, chronic pain, and depression.[61] These conditions are a leading cause of disability and/or death, and this burden places older adults at greater risk for premature death, poor functional status, unnecessary hospitalizations, adverse drug events, and nursing home placement.[62, 63] Chronic conditions also significantly influence health care costs: 95 percent of health care costs for older Americans can be attributed to chronic diseases.[64]

Chronic Disease Self-Management Education (CDSME) programs are low-cost, evidence-based disease prevention models that use proven techniques to improve health and quality of life. These interventions allow peer leaders to help individuals with chronic disease manage their conditions, improve their health status, and potentially reduce their need for more costly medical care.[65] ACL supports a variety of CDSME programs including:

- Chronic Disease Self-Management Program (CDSMP)
- Tomando Control de su Salud (Spanish version of CDSMP)
- Diabetes Self-Management Program (DSMP)
- Programa de Manejo Personal de la Diabetes (Spanish version of DSMP)
- Chronic Pain Self-Management Program
- Building Better Care Givers
- Positive Self-Management Program for HIV
- Cancer: Thriving and Surviving
- Wellness Recovery Action Plan (WRAP)

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

- EnhanceFitness®
- Healthy IDEAS
- HomeMeds
- Program to Encourage Active, Rewarding Lives (PEARLS)
- Walk With Ease

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[61] Gerteis J, Izrael D, Deitz D, LeRoy L, Ricciardi R, Miller T, Basu J. Multiple Chronic Conditions Chartbook. AHRQ Publications No, Q14-0038. Rockville, MD: Agency for Healthcare Research and Quality. April 2014.

[62] Parekh, AK, et al. 2011. Managing Multiple Chronic Conditions: A Strategic Framework for Improving Health Outcomes and Quality of Life. Public Health Rep. 126(4):460-71.

[63] Kramarow, E et al. 2007. Trends in Health of Older Americans, 1970-2005. Health Affairs (Milwood). Sep-Oct; 26 (5):1417-25.

[64] Centers for Disease Control and Prevention. The State of Aging and Health in America 2013. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2013.

[65] Brady, T.J., et al. 2013. "A Meta-analysis of Health Status, Health Behaviors, and Health Care Utilization Outcomes of the Chronic Disease Self-Management Program." Prev Chronic Dis 10:120112.

CDSME programs have been shown repeatedly, through multiple studies (including randomized control trials with both English and Spanish speaking populations) to be effective at helping participants adopt healthy behaviors and improve their psychological and physical health status.[66]A national study with over 1,100 CDSMP participants in 17 states documented many significant improvements including promoting better care, healthier communities, and wiser spending of health care dollars. Participants demonstrated improved communication with physicians, medication compliance, health literacy, self-reported health, less depression, and better quality of life, as well as reduced emergency room visits and hospitalizations and an estimated $360 per person net savings. The research team projected a national savings of $3.3 billion if CDSMP workshops were delivered to 5 percent of adults with multiple chronic conditions.[67]

CDSMEs emphasize an individual's role in managing his/her chronic condition(s). For example, the CDSMP in-person programs consist of a series of sessions that are conducted once a week for two and a half hours over six weeks in community settings such as senior centers, faith-based organizations, health care organizations, libraries, residential facilities, and tribal centers. The workshops are facilitated by two trained leaders, and people with varying chronic conditions participate together. One or both leaders are non-health professionals who also have a chronic condition. Workshop topics include:

- Techniques to deal with problems such as frustration, fatigue, pain, and isolation.
- Appropriate exercise for maintaining and improving strength, flexibility, and endurance.
- Appropriate use of medications.
- Communicating effectively with health professionals and family/friends.
- Nutrition.

ACL supports the delivery and sustainability of CDSME programs through competitive grants awarded to domestic public or private nonprofit entities funded by the Prevention and Public Health Fund. An expert peer review panel evaluates project proposals. In FY 2019, ACL awarded 11 fully funded grants for a three-year project period beginning May 1, totaling approximately $6.4 million. Additionally, ACL supported a National Chronic Disease Self-Management Education Resource Center to serve as a national clearinghouse of tools and information on CDSME, and assist states, the aging, disability and public health networks, and their partners in their efforts to increase access to and sustain evidence-based prevention programs, particularly CDSME programs.

During FY 2019, 24,044 participants engaged in one or more CDSME programs. By September 30, 2019, grantees and various partners had reached nearly 410,000 participants and implemented more than 37,000 workshops within 75 networks across the country (2009–

[66] Centers for Medicare & Medicaid Services, Report to Congress: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act. http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf Accessed March 23, 2018.

[67] Ahn S et al. The Impact of Chronic Disease Self-Management Programs: Healthcare Savings through a Community-Based Intervention. BMC Public Health. 2013. 13:1141. Doi: 10.1186/1471-2458-13-1141 Available at: http://www.biomedcentral.com/1471-2458/13/1141 Accessed March 23, 2018.

September 30, 2019). Additionally, participants rated their confidence managing a chronic condition after a workshop at 8 out of 10 (on a scale of 1 to 10).[68]

Grantees were successful in reaching their targeted populations. Of those participants reporting relevant data, 35 percent reported a disability; 25 percent identified themselves as a caregiver; 15 percent identified Hispanic or Latino ethnicity; and 30 percent identified their race as at least one of the following: Black or African American; American Indian or Alaska Native; Asian; Native Hawaiian or Pacific Islander; or other.[69]

[68] National Council on Aging, ACL CDSME Grantee Data. Accessed from National Chronic Disease Self-Management Education Database, September 2022

[69] ACL National Falls Prevention Database. Accessed May 15, 2020.

Behavioral Health

Behavioral health is essential to overall health. Behavioral health issues, such as depression, anxiety, substance misuse, and suicidal thoughts or actions, are not a normal part of aging—yet one in four persons aged 55 and over have experienced a behavioral health condition.[70] Behavioral health issues can greatly impact the independence, health, and well-being of older adults and their family caregivers. Untreated behavioral health conditions can exacerbate other health conditions, decrease life expectancy, and increase overall healthcare costs.[71] Distinctive barriers to the treatment of behavioral health conditions among the older adult population exist, such as discrimination, under-diagnosis, and inappropriate treatment.

The good news is that prevention, brief intervention, self-directed treatment, and recovery from behavioral health conditions are possible for individuals of all ages, including older adults. While the 2016 reauthorization of the OAA includes provisions focused on the prevention and treatment of behavioral health conditions, there is no funding in the OAA specifically designated for prevention, intervention, treatment, or recovery support services. States and communities have had to be creative in how they support these programs and services. Many aging network providers are working closely with behavioral health, primary care, and other partners to connect older adults with behavioral health screening and intervention resources. In addition, some providers are delivering evidence-based community interventions using a braided funding approach, which leverages a combination of funds from multiple sources. One such example is the funding of PEARLS, a treatment program designed to reduce symptoms of depression and improve quality of life among older adults, through funding from the OAA, the Substance Abuse and Mental Health Services Administration (SAMHSA), block grants, and contributions from private foundations.

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[70] Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). Older Americans Behavioral Health Issue Brief: Series Overview. Accessed January 5, 2018, at: https://www.ncoa.org/wp-content/uploads/Series-Overview-Issue-Brief-1.pdf

[71] World Health Organization (2016). Mental Health and Older Adults: A Fact Sheet. Retrieved March 23, 2018, at http://www.who.int/mediacentre/factsheets/fs381/en/

Falls Prevention Programs
(FY 2019: $5,000,000)

Falls can have a widespread and significant impact on the health of older adults and can reduce their ability to remain independent. According to the CDC one in four older adults (aged 65 or older) fall each year.[72] Falls are the leading cause of fatal and nonfatal injuries among older adults.[73] In 2015, the total medical costs for falls totaled more than $50 billion.[74]

Falls are not a normal part of aging and are preventable. There are known modifiable risk factors that can be addressed effectively with multifactorial approaches to significantly lower the risk of falls.[75] Community-based falls prevention programs are low-cost, evidence-based disease prevention models that help reduce falls and/or fall risk factors in older adults by improving strength, balance, mobility, medication review, and education on how to avoid falls, and potentially reduce their need for more costly medical care.[76] Examples of these programs include:

- A Matter of Balance (MOB): a program designed to reduce the fear of falling and increase activity levels among older adults.
- Bingocize: A socially engaging, group-based program that combines exercise, health education, and bingo.
- Moving for Better Balance (MBB): a research-based balance training regimen designed for older adults at risk of falling and people with balance disorders.
- Stepping On: a seven-week program focusing on four critical domains: balance and strength exercises; medication review; vision review; and home modifications.
- The Otago Exercise Program: a form of falls-prevention that helps prevent falls in older adults by strengthening muscles and improving balance.
- Tai Chi for Arthritis and Falls Prevention: program that incorporates classes twice a week for 8 weeks (or once a week for 16 weeks), along with home practice.

A Centers for Medicare & Medicaid Services (CMS) report to Congress indicated that MOB is associated with medical cost savings,[77] and a recent study showed a positive return on

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[72] U.S Centers for Disease Control and Prevention. (2016). Facts about Falls. Accessed September 26,2022March 23, 2018 at: http://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html

[73] WISQARS. Web-based Injury Statistics Query and Reporting System (WISQARS). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention 2021 [cited 2021 June]; Accessed September 30, 2022, from: www.cdc.gov/injury/wisqars

[74] Florence CS, Bergen G, Atherly A, Burns ER, Stevens JA, Drake C. Medical Costs of Fatal and Nonfatal Falls in Older Adults. Journal of the American Geriatrics Society, 2018 March, DOI:10.1111/jgs.1530, Accessed September 26, 2022

[75] Bergen G. Stevens MA. Kakara R. Burns EA. Understanding Modifiable and Unmodifiable Older Adult Fall Risk Factors to Create Effective Prevention Strategies. American Journal of Lifestyle Medicine. October 2019 DOI:10.1177/1559827619880529Gillespie LD, Robertson MC, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8669903/ Accessed September 26, 2022

[76] Gillespie WJ, Sherrington C, Gates S, et al. Interventions for preventing falls in older people living in the community (review). Cochrane Database Syst Rev. 2012; https://pubmed.ncbi.nlm.nih.gov/22972103/ Accessed September 26, 2022

[77] Report to Congress: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act. Accessed September 26, 2022, from: http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf.

investment for the implementation of Tai Chi: MBB, Stepping On, and Otago.[78] ACL continues to collaborate with partners at CDC's National Center for Injury Prevention and Control to share information about the implementation of evidence-based falls prevention programs at the community level and receive updates about training for health care professionals CDC's National Center for Injury Prevention and Control provides resources and training to healthcare professionals to make older adult fall prevention a routine part of their clinical routine and works with states, tribes, local health departments, and healthcare systems to implement and evaluate clinical fall prevention.

ACL has received dedicated funding for falls prevention programs through the Prevention and Public Health Fund (PPHF) from FY 2014 through FY 2019. In FY 2019, ACL published a competitive funding announcement, and external experts reviewed applications for this opportunity. ACL awarded a total of 12 grants to public and private nonprofit entities, including state agencies, universities, and community organizations. These three-year grants were intended to build capacity to increase the number of older adults and adults with disabilities who participate in evidence-based community programs and develop integrated, sustainable systems to reduce falls, fall risks, and fear of falling. All the grantees identified underserved target populations and partnering organizations to reach these populations, such as those living in rural areas, and organizations serving ethnically diverse and/or limited English-speaking populations. In FY 2019, evidence-based falls prevention programs reached 15,746 participants, bringing the total reached since 2014 to 144,937 participants.

In FY 2019, the National Falls Prevention Resource Center was funded by ACL. The National Falls Prevention Resource Center works collaboratively on behalf of the public, aging services network, and other stakeholders, to increase public education about the risks of falls and how to prevent them, as well as to support and stimulate the implementation and dissemination of evidence-based community programs and strategies that have been proven to reduce the incidence of falls among older adults.[79]

[78] Carande-Kulisa, V., et al. (2015), A cost–benefit analysis of three older adult fall prevention interventions, Journal of Safety Research, Accessed September 26, 2022, from: https://pubmed.ncbi.nlm.nih.gov/25662884/

[79] Accessed November 17, 2023: https://www.ncoa.org/professionals/health/center-for-healthy-aging/national-falls-prevention-resource-center

Caregiver Services

Families are the nation's primary providers of care, but 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 often are strapped for both. ACL's caregiver programs provide services that address the needs of informal caregivers, allowing many of them to continue to work while providing critically needed care.

Better support for this group of caregivers is critical because often it is their availability – whether they are informal family caregivers or unrelated friends, neighbors, and others who have a significant relationship with the person who volunteers their time – that determines whether an older person can remain in their home. In 2019, approximately 41.8 million adult caregivers provided uncompensated care to those 50 years of age and older.[80] In other words, approximately 16.8 percent of all adults provided care to someone age 50 years and older, an increase of approximately 2.5% from 2015 levels.[81] AARP estimated the economic cost of replacing unpaid caregiving in 2017 to be about $470 billion, an increase from $450 billion in 2009 (cost if that care had to be replaced with paid services).[82] The same study showed that, on average, family caregivers nationwide provide 34 billion hours of unpaid care to care recipients. Another recent study by the Rand Corporation estimated the economic cost of replacing unpaid caregiving to be about $522 billion annually.[83] The cost to replace that care with unskilled paid care at minimum wage was estimated at $221 billion, while replacing it with skilled nursing care could cost $642 billion annually. These estimates differ because of differences in methodology and definitions rather than contradictory data.

The demands of caregiving can be considerable. Recent research has demonstrated that caregiving tasks can, and do, go well beyond providing regular assistance with ADLs and instrumental activities of daily living (IADLs).[84] A 2012 study by AARP and United Hospital Fund revealed that, while family caregivers continue to perform the traditional ADL/IADL supports, their roles are expanding dramatically to include performing medical/nursing tasks of the type and complexity typically seen only in hospitals and other acute care settings.[85]

Such demands on family caregivers can lead to a breakdown of their health and can increase the risk for institutionalization of the care recipient. While research is mixed on the exact physical health impacts of family caregiving, several recent studies show that caregivers reporting mental and emotional strain as a result of their caregiving role are at higher risk for earlier

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[80] Research Report: Caregiving in the U.S. 2020: A Focused Look at Caregivers of Adults Age 50+. National Alliance for Caregiving and AARP Public Policy Institute. November 2020. https://www.caregiving.org/wp-content/uploads/2021/05/AARP1340_RR_Caregiving50Plus_508.pdf . Accessed October 20, 2022.

[81] Ibid.

[82] Valuing the Invaluable: 2019 Update, Charting a Path Forward. AARP Public Policy Institute. November, 2019.https://www.aarp.org/content/dam/aarp/ppi/2019/11/valuing-the-invaluable-2019-update-charting-a-path-forward.doi.10.26419-2Fppi.00082.001.pdf. Accessed May 5, 2020.

[83] *The Opportunity Costs of Informal Elder-Care in the United States.* The Rand Corporation, 2014. http://www.rand.org/pubs/external_publications/EP66196.html. Accessed February 15, 2018.

[84] ACL LongTermCare.gov website: https://acl.gov/ltc/basic-needs/what-is-long-term-care

[85] Home Alone: Family Caregivers Providing Complex Chronic Care. AARP and United Hospital Fund. October 2012. https://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/home-alone-family-caregivers-providing-complex-chronic-care-rev-AARP-ppi-health.pdf. Accessed February 15, 2018.

mortality.[86,87,88] Providing support that makes caregiving easier for family caregivers, such as information, counseling and training, respite care, or supplemental services, is critical to sustaining caregivers' ability to continue in that role. Seventy-five percent of the caregivers served by OAA programs report that these services allow them to provide care longer than they otherwise could.[89]

At the same time, ACL recognizes that it must also address the growing need for more caregivers every day. By 2025, it has been projected that there will be 14.8 million older adults living in the community age 65 and over with one or more ADL limitations, an increase of 2.6 million older adults (or a 21 percent increase between 2019 and 2025) needing caregiver assistance.[90]

National Family Caregiver Support Program
(FY 2019: $181,186,000)

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

The NFCSP provides a variety of supports to family and informal caregivers. In FY 2019, services provided included:[91]

- *Access Assistance Services*, which provided nearly 1.4 million contacts to caregivers assisting them in locating services from a variety of public and private agencies.
- *Counseling and Training Services*, which provided over 114,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving.

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[86] Perkins, M., Howard, V. J., Wadley, V. G., Crowe, M., Safford, M. M., Haley, W. E., Roth, D. L. (2013). Caregiving strain and all-cause mortality: Evidence from the REGARDS Study. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 68,* 504-512. doi:10.1093/geronb/gbs084.

[87] Roth, D. L., Haley, W. E., Hovater, M., Perkins, M., Wadley, V. G., & Judd, S. (2013). Family caregiving and all-cause mortality: Findings from a population-based propensity-matched analysis. *American Journal of Epidemiology, 178,* 1571-1578. doi:10.1093/aje/kwt225

[88] Roth, D. L., Fredman, L., & Haley, W. E. (2015, Special Issue). Informal caregiving and its impact on health: A reappraisal from population-based studies. *The Gerontologist, 55,* 309-319. doi:10/1093/geront/gnu177

[89] 2019 National Survey of Older Americans Act Participants. Accessed on November 14, 2022, at http://www.agid.acl.gov

[90] U.S. Census Bureau. Population Division. Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010, to July 1, 2019. Release Date: June 2020. Accessed on November 14, 2022 at https://www.census.gov/data/datasets/time-series/demo/popest/2010s-national-detail.html;. U.S. Census Bureau, "2017 National Population Projections," Table 3. Projected 5-Year Age Groups and Sex Composition of the Population for the United States: 2017 to 2060. Original Release Date: March 2018, Revised Release Date: September 2018. Accessed on November 14, 2022, at https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html; and Centers for Medicare & Medicaid Services, ACL analysis of 2017 Medicare Current Beneficiary Survey. Accessed on November 14, 2022, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/.

[91] AoA's FY 2019 State Program Report.

- *Respite Care Service*, which provided over 64,000 caregivers with nearly 6.5 million hours of temporary relief – at home or in an adult day care or nursing home setting – from their caregiving responsibilities.

Family and other informal caregivers are the backbone of America's long-term services and support system. On a daily basis, these individuals, the majority of whom are women, assist relatives and other loved ones with tasks ranging from personal care and homemaking to more complex health-related interventions like medication administration and wound care. Data from AoA's 2019 National Survey of OAA participants show that 21 percent of caregivers are assisting two or more individuals. Seventy-nine percent of caregivers are 60 or older, making them more vulnerable to a decline in their own health, and 35 percent describe their own health as fair to poor.[92] The demands of caregiving can lead to a breakdown of the caregiver's health. Nationally, approximately 11 percent of caregivers report that caregiving has caused their physical health to decline.[93] Caregivers often experience conflicts between work and caregiving. Among working caregivers caring for a family member or friend, 60 percent report work impacts due to caregiving such as having to rearrange their work schedule, decrease their hours or take an unpaid leave to meet their caregiving responsibilities.[94]

Survey results from caregivers served by the NFCSP indicate that the types of supports provided through the NFCSP can enable them to provide care longer (75 percent) while often continuing to work,[95] thereby avoiding or delaying the need for costly institutional care, including care financed by government sources such as Medicaid. Additionally, another study indicates that counseling and support for caregivers of individuals with Alzheimer's disease permit the care recipient to stay at home at significantly less cost, on average, for an additional year before being admitted to a nursing home.[96]

Data from AoA's 2019 National Survey of Older Americans Act Participants reveal that OAA services, including those provided through the NFCSP, are effective in helping caregivers assist their loved ones at home. Caregivers receiving services were asked whether the care recipient would have been able to live in the same residence if the services had not been available. Thirty-eight percent of the caregivers indicated that the care recipient would be unable to remain at home without the support services.[97] Those respondents were then asked to identify where the care recipient would be living without services. A significant majority of those caregivers, nearly 75 percent, indicated that the care recipient would most likely be living in a nursing home or an assisted living facility (see the Figure 1).[98]

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[92] 2019 National Survey of Older Americans Act Participants. Accessed on November 14, 2022, at http://www.agid.acl.gov.

[93] Center on Aging Society. (2005) How Do Family Caregivers Fare? A Closer Look at Their Experiences. (Data Profile, Number 3). Washington, DC: Georgetown University.

[94] Research Report: Caregiving in the U.S. 2015- A Focused Look at Caregivers of Adults Age 50+. National Alliance for Caregiving and AARP Public Policy Institute. June 2015. http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Care-Recipients-Over-50_WEB.pdf.

[95] 2019 National Survey of Older Americans Act participants. Accessed on November 14, 2022, at http://www.agid.acl.gov.

[96] Mittelman, M., Ferris, S., Shulman, E., Steinberg, G., Levin, B. (1996). A family intervention to delay nursing home placement of patients with Alzheimer's disease - A randomized controlled trial. *The Journal of the American Association*, 276(21), 1725-1731.

[97] 2019 National Survey of Older Americans Act Participants. Accessed on November 14, 2022, at http://www.agid.acl.gov.

[98] Ibíd.

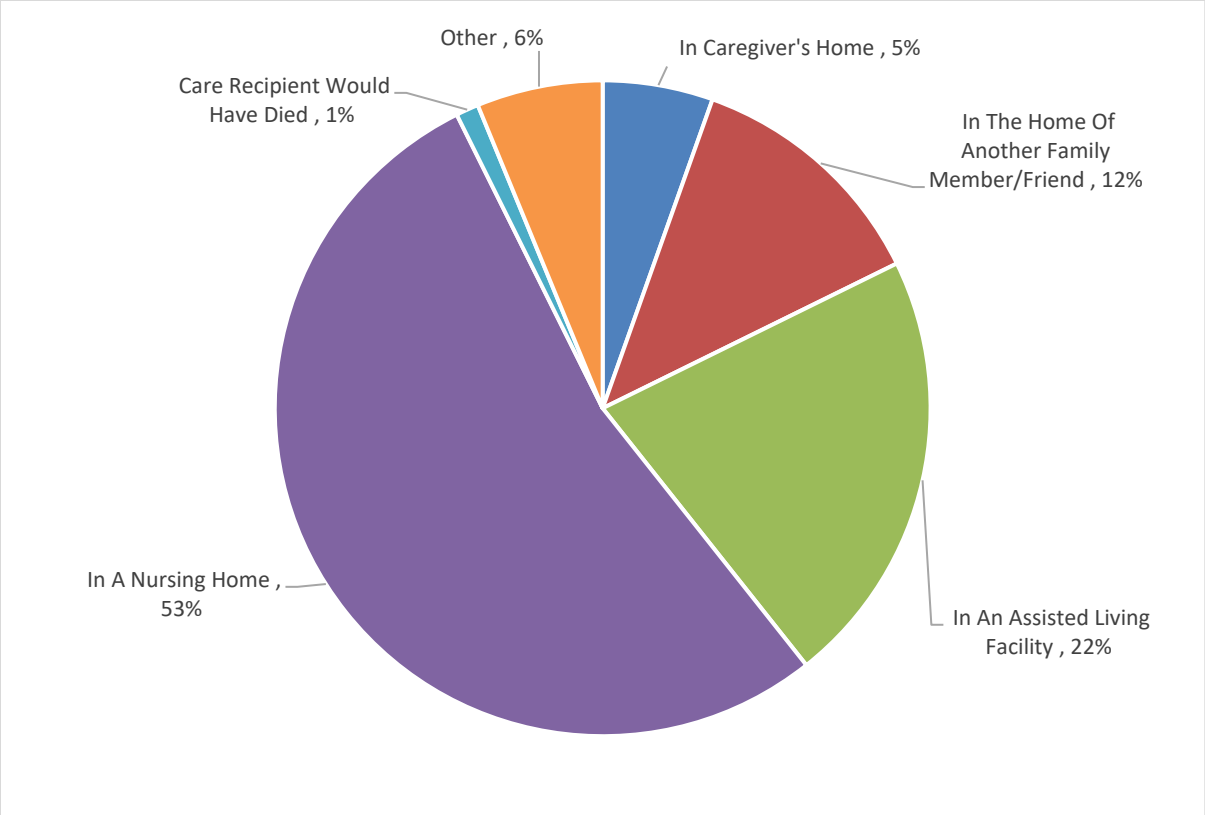

Figure 1. Where recipients of care would live if unable to have caregiver's supportive services.

Brain Health

The majority of older adults living in the community do not have problems with cognition which is, the ability to think, learn, remember, and manage their lives. Aging can, however, bring some changes in cognition that are normal, which includes some difficulty finding words, less ability to multi-task, and slight decreases in attentiveness.

Promoting brain health is critical to helping older adults maintain their cognition, independence, and overall health. ACL partnered with the National Institutes of Health and the Centers for Disease Control and Prevention to develop a suite of tools to support the aging services network in the delivery of brain health programing, including the Brain Health toolkit. The toolkit is designed to promote brain health among older adults, people with disabilities, and their caregivers and includes modules covering *Brain Health Basics, Medicine, Age and Your Brain, Brain Injury* and *Dementia*.[99]

The educational materials included in the toolkit address several risks to brain health, including accidents; medication use; smoking and alcohol misuse; health conditions like heart disease and diabetes; poor diet; insufficient sleep; and lack of physical and social activity. For each of these risks the toolkit provides evidence-based information and governmental resources to support

[99] Accessed November 17, 2023: https://acl.gov/brain-health

professionals, older adults, and people with disabilities promote and maintain brain health. Many of the resources, like ACL's nutrition, chronic disease self-management education, falls prevention, and medication programs, promote overall health, including brain health.

The Brain Health toolkit is maintained through ACL, NIH, and CDC continued collaboration. This work occurs through the U.S. Department of Health and Human Services' National Plan to Address Alzheimer's Research, Care and Services.[100]

Alzheimer's Disease Programs Initiative (ADPI)

(FY 2019: $23,500,000)

In FY 2019, the ADPI cooperative agreement program continued to support community and state efforts to address identified gaps in existing systems of support for caregivers and people living with Alzheimer's disease (AD) and Alzheimer's disease-related dementias (ADRD). Through the ADPI, ACL issued two classes of competitive grants – to States that want to improve or develop their dementia systems capability, and to existing dementia-capable community-based organizations that are prepared to address identified service gaps through expansion of their on-going activities. Collectively these grants seek to achieve the following objectives:

- Create statewide, person-centered, dementia-capable home and community-based service systems.
- Translate and implement evidence-based supportive services for persons with AD/ADRD and their caregivers at the community level.
- Work with public and private entities to identify and address the special needs of persons with AD/ADRD and their caregivers.
- Offer direct services and supports to thousands of persons with AD/ADRD and their caregivers.

As a complement to and in support of the state and community grant program, ACL funds a training and technical assistance resource center, the National Alzheimer's and Dementia Resource Center.[101] In addition to developing tools to support state and community grantee efforts, the Center also develops materials from which the public also benefits.

All states and communities that participate in ADPI are funded to improve home and community-based services (HCBS) for persons living with AD/ADRD and their caregivers, focusing program resources toward enhancing the dementia-capability of the systems within the communities in which they operate. Dementia-capable systems are those that are designed to improve the responsiveness of home and community-based services systems to persons living with dementia and their caregivers by ensuring access to sustainable, integrated long-term services and supports. Each of the funded programs must meet the following requirements:

- Implement at least one dementia-specific evidence-based or evidence-informed intervention.

[100] https://aspe.hhs.gov/reports/national-plan-address-alzheimers-disease-2019-update-0
[101] https://nadrc.acl.gov/

- Dedicate 50 percent of program resources to the provision of direct services, including but not limited to provision of respite, care management, increased availability of assistive technology, dementia, and behavioral symptom management training to thousands of individuals and caregivers, both paid and unpaid; and 25 percent cost-sharing through either in-kind or cash match.

Through targeted partnerships and community engagement, grantees can implement a broad range of services and supports to persons living with AD/ADRD and their caregivers.

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

ACL community grantees are also required to address specific service gap areas that align with recommendations from the National Alzheimer's Project Act Advisory Committee and include the following areas:

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

In FY 2019, ADPI funded programs dedicated to the development and enhancement of dementia-capable systems were operating in communities across 34 states with many states having more than one active grant. For example, in 2019 there were 14 active grants around the state of California, four in Hawaii, Illinois and Texas, as well as 12 states with two or more grants. The programs all include significant emphasis on continuous quality improvement and comprehensive program evaluation.

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

Nutrition and Supportive Services

(FY 2019: $34,208,000)

ACL provides grants for Native American Nutrition and Supportive Services to eligible tribal organizations to support the delivery of nutrition and home and community-based supportive services to American Indian, Alaska Native, and Native Hawaiian elders.

An estimated 1 million persons age 60 and over identify themselves as American Indian or Alaska Native (AI/AN) alone or in combination with another racial group.[102] Over 607,000 of those elders identify as American Indian or Alaska Native with no other racial group.[103] Between 2000 and 2010, the number of older American Indian and Alaska Native (AI/AN) adults increased by 40.5 percent, a growth that is 2.7 times greater than that of the overall population of older adults over the same 10-year period.[104] In addition, this rapidly growing population is also experiencing some of the highest rates of disability, chronic disease, and poverty in the United States.[105, 106] Because of the combined factors of an aging population and high disability rates, AI/ANs have a great need for home and community-based services access in their communities.

Title VI services are unique among federal programs for older adults because they are responsive to the cultural traditions of Native American communities and represent an important part of each community's comprehensive elder services. When offered as part of a portfolio of support to elders, they can help to reduce the need for costly nursing home care and medical interventions for people who receive the services.

Native American Nutrition and Supportive Services grants support a broad range of services to older Native Americans, including adult day care, transportation, congregate and home-delivered meals, information and referral, personal care, help with chores, and other services. Currently, ACL's congregate meals program reaches 42 percent of eligible Native American elders in participating tribal organizations, home-delivered meals reach 12 percent of such persons, and supportive services reach 30 percent of such persons.[107] These programs, which can help to reduce the need for costly nursing home care and medical interventions, are responsive to the cultural diversity of Native American communities. Services provided by this program in FY 2019 included:

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[102] U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population by Sex, Single Year of Age, Race Alone or in Combination, and Hispanic Origin for the United States: April 1, 2010, to July 1, 2019. Released July 2020. Accessed on November 16, 2022, at https://www.census.gov/data/tables/time-series/demo/popest/2010s-national-detail.html.

[103] U.S. Census Bureau, Population Division. Annual Estimates of the Resident Population by Sex, Single Year of Age, Race, and Hispanic Origin for the United States: April 1, 2010, to July 1, 2019. Released July 2020. Accessed on November 16, 2022at https://www.census.gov/data/tables/time-series/demo/popest/2010s-national-detail.html.

[104] Administration on Aging, U.S. Population by Age: 65+ Minority Population Comparison using Census 2000 and Census 2010 (July 1, 2011).

[105] National Council on Disability, "Understanding Disabilities in American Indian and Alaska Native Communities: Toolkit Guide" (2003).

[106] Centers for Disease Control and Prevention, "CDC Health Disparities and Inequalities Report – United States" (2013).

[107] ACL's OAA Title VI Program Performance Report, PY 2018. Title VI of the Older Americans Act permits tribes to establish age of eligibility for services below age 60. Calculation based on eligible population as reported in grantee applications.

- *Transportation Services*, which provided over 762,852 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical activities.[108]
- *Home-Delivered Nutrition Services,* which provided over 2.6 million meals to more than 22,000 homebound Native American elders; the program also provides critical social contacts that help to reduce the risk of depression and isolation experienced by many home-bound Native American elders.[109]
- *Congregate Nutrition Services*, which provided more than 2.6 million meals to more than 65,000 Native American elders in community-based settings, as well as an opportunity for elders to socialize and participate in a variety of activities, including cultural and wellness programs.[110]
- *Information, Referral and Outreach Services*, which provided over 813,000 hours of outreach and information on services and programs to Native American elders and their families, thereby empowering them to make informed choices about their service and care needs.[111]

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

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

Caregiver Support Services
(FY 2019: $10,056,000)

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

Native American Caregiver Support Services funding is allocated to eligible tribal organizations based on their share of the American Indian, Alaska Native, and Native Hawaiian population

[108] ACL's OAA Title VI Program Performance Report, PY 2019.
[109] Ibid.
[110] Ibid.
[111] Ibid.

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

Grants assist American Indian, Alaska Native and Native Hawaiian families caring for older relatives with chronic illness or disability and grandparents caring for grandchildren. The program provides a variety of direct services that meet a range of caregiver needs, including information and outreach, access assistance, individual counseling, support groups and training, respite care, and other supplemental services. In FY 19, tribal grantees provided over 103,000 hours of respite care, delivered over 5,300 hours of caregiver training, and assisted over 22,300 caregivers to access needed services.[112] Tribal organizations coordinate with other programs, including the Volunteers in Service to America (VISTA) program, to help support and create sustainable caregiver programs in Native American communities (many of which are geographically isolated).

[112] Ibid.

PART III: ELDER RIGHTS

ACL's Elder Rights Support Activities programs provide grants, technical assistance, and other resources to states and communities to uphold the rights of older Americans and protect them from abuse, neglect, and exploitation. The Elder Rights Support Activities include the National Center on Elder Abuse, the National Long-Term Care Ombudsman Resource Center, the National Center for Law and Elder Rights, and the Legal Assistance Enhancement Grant Program Together with ACL's Elder Justice and Adult Protective Service programs, Long-Term Care Ombudsman Program, and the national network of local legal assistance providers, the Elder Rights Support Activities program plays a critical role in promoting independence, autonomy and well-being of older adults.

Elder abuse is a significant public health and human rights problem. Available prevalence data suggest that at least 10 percent (or 5 million) of older Americans experience abuse each year, and many of them experience it in multiple forms.[113] In addition, data from Adult Protective Services (APS) agencies show an increasing trend in reports of elder abuse, despite estimates that as few as 1 in 14 cases of elder abuse and 1 in 44 cases of financial exploitation come to the attention of authorities.[114,115]

Elder abuse results in a wide range of negative health impacts, including an increased likelihood of injury and chronic health conditions, both of which significantly impact health care expenditures. On average, older people have more chronic diseases and access the health care system at higher rates than other age groups. Older adults who are victims of violence have additional health care problems and higher premature mortality rates than non-victims. Older victims of even modest forms of abuse have dramatically (300 percent) higher morbidity and mortality rates than non-abused older people.[116] Research has also demonstrated that older adults who are victims of violence have more health care problems than other older adults, including increased bone or joint problems, digestive problems, depression or anxiety, chronic pain, high blood pressure, and heart problems.[117]

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[113] Beach SR, Schulz R, Castle NG, Rosen J. Financial Exploitation and Psychological Mistreatment Among Older Adults: Differences Between African Americans and Non-African Americans in a Population-Based Survey. Gerontologist 2010.
Acierno R, Hernandez MA, Amstadter AB, Resnick HS, Steve K, Muzzy W et al. Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study. American Journal of Public Health 2010; 100(2):292-297.

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

[115] National Research Council. Elder Mistreatment: Abuse, neglect, and exploitation in an Aging America. Washington, D.C.: The National Academies Press, 2003.

[116] 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. https://webmail.hhs.gov/exchange/ste.whittier.aoa/Drafts/RE: VAW Steering Committee-Query HCP-2.EML/1_text.htm

[117] Bitondo Dyer C., Pavlik V. N., Murphy K. P., and Hyman D. J. (2000). "The high prevalence of depression and dementia in elder abuse or neglect." Journal of the American Geriatrics Society. 48:205-208.
Burt, M. and Katz, B. "Rape, Robbery, and Burglary: Responses to Actual and Feared Criminal Victimization, with Special Focus on Women and the Elderly," Victimology: An International Journal 10 (1985): 325-358.
Mouton C. P., Espino D. V. (1999). "Problem-orientated diagnosis: Health screening in older women." American Family Physician. 59: 1835.
Fisher, B.S., and Regan, S.L. (2006). "The Extent and Frequency of Abuse in the Lives of Older Women and Their Relationship with Health Outcomes." The Gerontologist, 46: 200-209.

Victims of elder abuse also have significantly higher levels of psychological distress and lower perceived self-efficacy than older adults who have not been victimized.[118] For older victims of sexual violence the negative health impacts of abuse are even more pronounced. One study found that 12.7 percent of older women in the study group reported a history of sexual assault, all of whom experienced significantly increased risks of breast cancer and arthritis. Also, those who experienced repeated violence were up to four times more likely to develop these chronic conditions than women who were never abused.[119]

Prevention of Elder Abuse and Neglect

(FY 2019: $4,773,000)

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

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

Two examples of a state's elder abuse prevention activities during FY 2019 include Connecticut (CT), which has used a portion of the Elder Abuse Prevention funds to support the work of the Coalition for Elder Justice in CT. The Coalition has worked collaboratively with the Attorney General's Office to support the new "Elder Justice Hotline," present at the CT Coalition to End Homelessness Annual Training Institute, promote the Walk for WEAAD hosting weekly walks across the state to raise awareness, provide training to state and municipal police through partnership with the CT Police Academy, and provide monthly webinars geared toward attorney and social workers that are appointed as conservators in collaboration with the Office of Probate

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

Stein, M. & Barrett-Connor, E. (2000). "Sexual Assault and Physical Health: Findings from a Population-Based Study of Older Adults." Psychosomatic Medicine. Vol. 62: 838-843.

[118] Fulmer, T., Rodgers, R. F., & Pelger, A. (2013). Verbal mistreatment of the elderly. Journal of Elder Abuse & Neglect, 26(4), 351–364; Mouton, C. P., Rodabough, R. J., Rovi, S. L. D., Robert, G., Brzyski, R. J., & Katerndahl, D. A. (2010). Psychosocial effects of physical and mental abuse in post-menopausal women. Annals of Family Medicine, 8, 206–213. doi: 10.1370/afm.1095

Comijs, H.C., Penninx, B.W.J.H., Knipscheer, K.P.M., & van Tilburg, W. (1999). Psychological distress in victims of elder mistreatment: The effects of social support and coping. Journal of Gerontology, 54B (4), P240-P245.

[119] Stein, M. & Barrett-Connor, E. (2000). "Sexual Assault and Physical Health: Findings from a Population-Based Study of Older Adults." Psychosomatic Medicine. Vol. 62; pp 838-843.

Administration and the CT Bar Association, Elder Law Section. In Oregon, Elder Abuse Prevention funding supported collaboration between local AAAs and the state Senior & Disability Services (S&DS) to launch a multi-media elder abuse awareness campaign that included paid commercials on local television, advertisements on local radio, video PSAs, social media posts, and interviews with local radio stations.

National Center on Elder Abuse

(FY 2019: $765,152)

To support and enhance the activities of state and local programs to prevent elder abuse, neglect, and exploitation, ACL 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 promotes relevant news and resources; collaborates on research; provides consultation, education, and training; identifies, and provides information about promising practices and interventions; answers inquiries and requests for information; operates a listserv forum for professionals; and advises on program and policy development.

NCEA also facilitates the exchange of promising practices and strategic approaches for revealing and prosecuting fraud in areas, such as telemarketing and sweepstakes scams that target older adults.

In FY 2019, NCEA addressed the heightened risk of elder abuse through increased communication and resources related to caregiving in the community and in facilities, collaborating with new and continuing partners to reach audiences through virtual presentations, podcasts, radio shows, blogs, and social media.

In FY 2019, the NCEA ACL website had 321,436 views across 162,896 users.[120] The NCEA webpages on the Center on Elder Mistreatment website had 119,167 views across 50,277 users.[121] During this period, NCEA shared 206 Facebook posts and 612 tweets, with a combined post impression of over 1,219,571.

During FY 2019, NCEA created several publications for public and professional audiences, including the following titles:

- *12 Things Everyone Can Do to Prevent Elder Abuse* (available in four languages)
- *Six Ways to Care for Yourself When Caring for Someone with Dementia* (in seven) languages)
- *What I Should Know About Opioid Pain Medicine*
- *Mandated Reporting of Abuse of Older Adults and Adults with Disabilities*

NCEA launched a Reframing Elder Abuse webpage on the ACL website along with a Reframing Elder Abuse monthly eNewsletter.

[120] https://ncea.acl.gov/home#gsc.tab=0
[121] https://eldermistreatment.usc.edu/

Approximately 440 hours were spent responding to 1,218 requesters seeking advice and assistance by email, phone, and social media. The most common types of requests received were individual case consultations (65%) from family members and elders alleging abuse, followed by professional consultation requests and public awareness-related requests. NCEA also contributed to a Multi-Disciplinary Team training video on remote meeting facilitation to review cases, the *Handbook on Rural Elder Abuse,* and a financial fraud and exploitation module with the American College of Financial Advisors. NCEA volunteers and interns assisted the Han Research Lab in studying characteristics of elder abuse cases alleged in technical assistance requests (*Important Findings from the NCEA Resource Line* blog).

On World Elder Abuse Awareness Day (WEAAD), Ageless Alliance and NCEA co-hosted a Twitter chat to discuss WEAAD efforts around the world, with 608 tweets shared and 287,835 users reached.[122] FY 2019 was truly a global year; 292 WEAAD events took place in the United States, and 50 events in countries from South Korea to Scotland. NCEA's WEAAD social media campaign for the public garnered 253,226 impressions and 13,904 engagements.

National Center on Law and Elder Rights

(FY 2019: $1,280,731)

The National Center on Law and Elder Rights (NCLER) provides professionals in law and aging across the United States with training, technical assistance, and resources to assist older clients and consumers with high-quality legal assistance in areas of critical importance to their independence, health, and financial security. It serves to enhance the quality, cost effectiveness, and accessibility of legal assistance and elder rights protections available to older adults with social or economic need. NCLER provides resource support to a broad range of legal, elder rights, and aging services professionals and advocates, including:

- Legal assistance providers
- Legal assistance developers
- Long-term care ombudsmen
- State units on aging
- Area agencies on aging and aging & disability resource centers
- Senior legal helplines
- Adult protective services
- Others involved in protecting the rights of older adults

NCLER serves the following core support functions for aging and legal networks:

- Case consultation for professionals and advocates in the field of law and aging to assist in the resolution of complex legal problems impacting older adults.
- Legal training for professionals and advocates from aging and legal services networks on a wide range of legal and elder rights issues experienced by older Americans with economic and social need.

[122] https://eldermistreatment.usc.edu/weaad-home/tools-and-tips/

- Technical assistance in the development of legal service delivery systems that address priority issues impacting older adults.

In FY 2019, NCLER provided legal training on a broad range of priority legal issues that included Medicare appeals, public benefits for immigrants, supported decision-making; Social Security post-eligibility tips; Social Security Insurance overpayment; advance planning documents; managed long-term services and supports and service authorization; consumer law and nursing facilities; grandparent and non-parent kinship caregivers; reverse mortgages; utility rights; mandatory and permissive reporting; scams; rural financial exploitation; signs of abuse, neglect, and financial exploitation; accessing behavioral health; and how to respond when the guardian is an abuser.

NCLER also provided case consultation on priority legal issues, including, eviction defense in assisted living facilities.

NCLER significantly increased its technical assistance presence, providing one-on-one consultations to legal and aging network providers across the country. This included consulting with programs on issues such as developing state-specific Financial Exploitation Guides, working with social workers and other non-lawyers; improving intake procedures; and strengthening outreach to rural communities.

The provision of case consultation, training, technical assistance, and other legal resources enhances the ability of legal and aging service providers and advocates to help older adults maintain independence, live in their homes and communities, make their own decisions, and maintain their financial security. The NCLER website and other elders' rights-related websites are accessible through Elderjustice.acl.gov.[123]

Legal Assistance Enhancement Programs (LAEP)
(FY 2019:* $1,256,398*)

ACL's Legal Assistance Enhancement Program (LAEP) supports legal assistance enhancements and innovations in four key areas to older adults with the greatest economic need and greatest social need:

- Outreach efforts to effectively educate clients and the aging network about legal assistance.
- Intake strategies that are integrated with the broader aging services network.
- Essential partnerships within and outside the aging services network that serve communities of older adults.
- Delivery of full-range legal assistance, from legal advice through representation.

In FY 2019, ACL funded six organizations with three-year grants to address gaps in access to elder rights supports and strengthen elder rights and other programs serving older adults.

[123] https://ncler.acl.gov/home

Grantees address a diverse set of issues, such as supporting grandparents raising grandchildren, utilizing technology to advance elder justice, a Medical-Legal Partnership, reaching underserved communities, and disaster recovery. The six grantees were:

- Cherry Street Services, Inc.
- Idaho Legal Aid Services, Inc. (ILAS)
- Legal Services of Alabama (LSA)
- Legal Services of North Florida (LSNF)
- Public Law Center (PLC)
- SeniorLAW Center

Pension Counseling and Information Program

(FY 2019: $1,857,683)

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

Today, there are more than 700,000 private (as well as thousands of public) pension and retirement plans in the United States. Thousands of Americans reach retirement age each year, only to be told that they will not receive the pension benefits they expected. Because individuals have generally worked for several employers, which may have merged, sold their plans, or gone bankrupt, it is very difficult for most people to know where to get help in finding out whether they are receiving all 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 that people face are just as complex, and good help is just as hard to find – even more so for those with only modest benefits at stake. The role of the Pension Counseling and Information Program (PCIP) is to help ensure that all older Americans have access to the help they need to secure the employer-sponsored retirement benefits they have earned – benefits that are critical to their ability to live independently and with dignity after a lifetime of productive employment. The PCIP provides help that would be otherwise unavailable, by assisting individuals in understanding and exercising their pension rights. The program promotes the financial security of older individuals by offering them the help they need to receive the pension benefits they have earned. The income, in turn, provides increased opportunities for choice and independence.

In FY 2019, ACL funded six regional counseling projects covering 30 states and a technical assistance resource center to assist older Americans in accessing information about their retirement benefits and help them negotiate with former employers or pension plans for due compensation. These projects are ongoing, and the six regional counseling projects are:

- The Mid-American Pension Rights Project, serving Michigan, Ohio, Indiana, Tennessee, Pennsylvania, and Kentucky.

- The New England Pension Assistance Project, serving Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont (and the Illinois Pension Assistance Project).
- The South-Central Pension Rights Project, serving Arkansas, Louisiana, Missouri, New Mexico, Oklahoma, and Texas.
- The Upper Midwest Pension Rights Office, serving Iowa, Minnesota, North Dakota, South Dakota, and Wisconsin.
- The Mid-Atlantic Pension Counseling Project, serving New York and New Jersey.
- The Western States Pension Counseling Project, serving Arizona, California, Hawaii, and Nevada.

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

Data show that since the program's inception through 2018, the Pension Counseling projects have recovered $254 million in retirement benefits for more than 61,500 retirees. With a relatively small federal investment, the program has a return of more than $9.00 for every federal dollar invested in the program. These recoveries demonstrate that pension counseling is not only necessary, but that it can be provided efficiently and effectively. Some projects demonstrate an even higher return on investment. For example, the Mid-America Pension Rights Project, operated by ElderLaw Michigan, calculated for their reporting period of July 1, 2018, to December 31, 2018, they have helped to recover pension benefits presently valued at $2,027,918.82—a return of $20 for every federal dollar invested in the operation of this project. In addition to the dollars recovered by PCIP-funded organizations on behalf of clients, ACL can measure efficacy of the program through number of clients served, which are tracked on a bi-annual basis through six-month progress reports of project successes, recovered funds, and client intake.

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

- The Pension Action Center/Illinois Pension Assistance Project helped a man who had worked at a factory manufacturing railroad wheels in Bensenville, Illinois, in the 1960s, 1970s, and 1980s. The factory closed in 1988. He then went on to have a successful career as an electrician. When he approached retirement age, he contacted the company that once owned the factory, but was told that they had no record of him or his benefits. The staff at the Pension Action Center/Illinois Pension Assistance Project worked with him, the U.S. Department of Labor, and the Pension Benefit Guaranty Corporation to prove that he was erroneously dropped from the pension plan. He now receives a monthly benefit of approximately $350 per month, with an estimated value of $47,000 over his lifetime.
- The Upper Midwest Pension Rights Project assisted a woman who was the surviving spouse of a Participant to obtain her surviving spouse pension. After working for the same employer for more than 28 years, the client's husband had to retire early due to a disability. After the death of her husband, the client contacted the Pension Plan, inquiring

about her eligibility for a surviving spouse pension benefit. The client was informed that there was no record that she was entitled to any survivor benefits. The Project contacted the Pension Plan and filed a claim on behalf of the client. The client received a retroactive lump-sum payment of $4564.86 and an ongoing monthly benefit of $800.81 for the remainder of the client's lifetime.

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

Long-Term Care Ombudsman Program
(FY 2019: $ 16,885,000)[124]

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

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

The OAA requires LTC Ombudsman programs to:

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

Improving and Evaluating LTC Ombudsman Program Services

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

Complaint Investigation and Resolution

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

[124] This amount reflects Title VII-2 designated as Ombudsman Program Activity funds. States also utilize other Older Americans Act and other funding sources to operate the LTC Ombudsman program.

Ombudsman programs nationwide completed resolution work on 198,502 complaints and resolved 71.5 percent of these complaints to the full or partial satisfaction of the resident or complainant.[125]

Seventy-one and a half percent of complaint resolution work occurred in nursing facility settings, twenty-seven percent occurred in board and care, assisted living or other residential care communities; and one and a half percent were associated with non-facility settings or services to facility residents by an outside provider.

Residents were the primary complainant in nursing facilities (44 percent) and in board and care, assisted living and other residential care communities (36 percent);[126]

The five most frequent nursing facility complaints handled by LTC Ombudsman programs in FY 2019 were:

1. Discharge/ eviction - planning, notice, procedure, implementation, including abandonment.
2. Failure to respond to requests for assistance.
3. Activities and social services.
4. Dignity and respect – staff attitudes.
5. Medications - administration, organization.

The five most frequent complaints in board and care, assisted living, and other residential care communities handled by LTC Ombudsman programs in FY 2019 were:

1. Activities and social services.
2. Discharge/eviction – planning, notice, procedure, implementation, including abandonment.
3. Medications – administration, organization.
4. Food service - quantity, quality, variation, choice, condiments, utensils, menu.
5. Dignity and respect – staff attitudes.

LTC Ombudsman programs devote significant effort to addressing improper discharge and eviction. This complaint was the most common for nursing home residents in FY 2019 and is best illustrated by the following example of a systemic strategy.

In FY 2019, the LTCOP continued to focus on concerns regarding involuntary discharges, specifically related to those for non-payment which had been identified in one region. A task force was started, regularly addressing issues related to inappropriate discharge, transfer, and eviction. Each regional program was asked to evaluate discharge notices to determine the prevalence. The State Office and a large team of stakeholders met bi-monthly to discuss progress

[125] FFY 2019 National Ombudsman Reporting System (NORS) is the source for this and other data in this section. States report NORS data annually to ACL.

[126] In FY 2019, Ombudsmen opened 123,815 new cases (a case contains one or more complaints originating from the same person(s)), and completed resolution on 123,863 closed cases, containing, 198,502 complaints.

related to specific cases and are continuing to identify needs for potentially pursuing legislative action to assist with combatting some of the issues identified by the group. The program accessed legal resources to represent residents.

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

LTC Ombudsman Program Activities

In addition to resolving complaints, LTC Ombudsman programs provide services that address complaints with residents and serve as a resource on rights, quality care and community options. In FY 2019, LTC Ombudsman programs provided:

- Routine visits to 70 percent of nursing facilities and 30 percent of board and care, assisted living, and other residential care communities at least quarterly. These visits ensure that residents have regular access to Ombudsman services.
- Information and assistance to individuals (over 425,000 instances) on topics such as long-term services and supports options; Medicaid eligibility; discharge and eviction rights; and other federal and state policies affecting residents.
- Consultations and information to long-term care facility staff (over 134,000 instances); on topics such as residents' rights, person-centered care practices, and discharge and eviction questions.
- Resident and family council support, providing technical assistance, training and information to resident councils and family councils (23,715 sessions).
- Training of long-term care facility staff (4,418 sessions).
- Community education (9,926 sessions).
- Coordination with licensing and survey entities, participating in 17,168 facility survey-related activities as resident advocates.

Systems Advocacy

In addition to individual problem resolution, Ombudsman programs advocate for resident interests in public policy arenas. The OAA requires Ombudsman programs to analyze, comment on, and recommend changes in laws, regulations, and government policies and actions to benefit residents. In addition to addressing improper evictions, Ombudsman programs reported on work to address systems-level issues. For example, when several small residential care facilities closed the Ombudsman advocated for a systemic policy solution on behalf of residents with behavioral health needs. The closure of small facilities impacts residents with behavioral health issues, as the loss of these homes impacts the ability of residents with behavioral health conditions to find adequate housing and leaves those who are newly entered into Adult Protective Services (APS) system remaining in the hospital or in hotel rooms. The Ombudsman advocated for an increase of alternative settings for individuals with behavioral health needs and return of individuals in APS custody to their homes, with assistance from the Medicaid agency.

How LTC Ombudsman Programs Operate

There are 53 State LTC Ombudsman programs (in 50 states, plus the District of Columbia, Puerto Rico, and Guam). In most states, the Office of the State LTC Ombudsman is within the state unit on aging or another state agency. In others, the Office resides in a private, non-profit agency. Most states have contracts with or through area agencies on aging to provide direct ombudsman services to residents. In FY 2019. there were 517 designated local Ombudsman entities.

In FY 2019, 1,365 full-time equivalent staff and 5,946 volunteers—all trained and designated to investigate and resolve complaints and provide Ombudsman program services to residents. An additional 2,149 volunteers also assisted in program operations in ways other than complaint resolution.

National Long-Term Care Ombudsman Resource Center Activities

To effectively solve problems, Ombudsman programs must remain up to date on the latest long-term care developments. Therefore, ACL supports the National Ombudsman Resource Center (NORC), which provides training, technical assistance, and program management expertise to Ombudsman programs. [127] In FY 2019, the National Consumer Voice for Quality Long-Term Care operated the NORC in partnership with ADvancing States.

In FY 2019, the NORC provided training and technical assistance on issues including:

- Using regulations and guidance as advocacy tools to address transfer and discharge complaints.
- Changes to the federal nursing home regulations, including implementation of ACL's final rule for State LTC Ombudsman programs.
- The effects of the opioid crisis on long-term care residents.

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

Growth in home and community-based services (HCBS) and Medicaid managed Long-Term Services and Supports (LTSS) and its impact on ombudsman services

Federal and state policy changes—including the promotion of Medicaid HCBS through waivers and other statutory options, the rapid growth of Medicaid managed LTSS, and demonstration projects to serve persons receiving both Medicare and Medicaid (i.e., Financial Alignment Initiative, sometimes called the "duals demonstrations") are creating opportunities for Ombudsman engagement and system development. As these services expand and provide more options for residents, Ombudsmen work to represent their interests and concerns and to ensure

[127] https://ltcombudsman.org/

that strong beneficiary support systems are in place, which increases the complexities in LTC Ombudsman program services and supports.

Increasingly, individuals live in residential settings other than nursing homes, including board and care homes, assisted living facilities, and other residential care communities (known by various names under state laws). As a result, LTC Ombudsman programs report increasing work, both at the individual complaint and the systems levels. In FY2019, 27 percent of complaints handled by the LTC Ombudsman program were about residential care facilities.

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

The following case example illustrates the effectiveness of LTC Ombudsman program complaint resolution during this period:

> The Office of the Long-Term Care Ombudsman was contacted by residents of a local assisted living community that was proposing rental increases ranging from 33 – 43 percent, that would have meant an increase of $1200 -$1600 per month. Residents who were part of the original group occupying the community were told their rates would be grandfathered in due to being the first to move into the community. The Ombudsman ultimately brought these issues to the attention of Ombudsman at the Office of the Attorney General. The facility ultimately reduced the fee increase to 3-5 percent, saving each resident tens of thousands of dollars each year.

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

Aging and Disability Resource Centers/No Wrong Door System

(FY 2019 $8,119,000)

Aging and Disability Resource Centers (ADRCs) support state-wide efforts to develop a more efficient, cost-effective, and consumer-responsive system of providing information and access to long-term services and supports. This coordinated approach is referred to as the No Wrong Door (NWD) System. States enhance their NWD Systems by designating ADRCs and other community-based organizations supporting access to services. In these systems, multiple agencies retain responsibility for their respective services but coordinate to integrate access to those services through a single, standardized process. Community-based organizations like ADRCs deliver one-on-one, person-centered counseling and serve as consumer-friendly entry points to the system.

Without these services, people who need long-term services and supports (LTSS) often do not have access to accurate and complete information, which can lead them to select options that are

more expensive than necessary.[138] By helping them connect to the services they need to live in the community, ADRCs/NWD systems help divert individuals from more costly forms of care, such as nursing homes, and help them avoid unnecessary hospital admissions and readmissions. A study of Medicaid beneficiaries found that initiating services through community-based LTSS is associated with dramatic differences in future long institutional stays, with less than one percent of people initiating LTSS in the community experiencing a long institutional stay and 73 percent of people initiating care in an institution subsequently experiencing a long stay.[139] Since institutional care can cost three times as much as in-home supports, NWD systems are critical to decreasing health care utilization costs and are a key component in transforming states' long-term services and support programs. Services for all populations and all payers provided by ADRC/NWD systems include:

- Targeted discharge planning, care transition, and nursing home diversion support that integrates 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 hospitalization, rehabilitation, or skilled nursing facility stay.
- One-on-one, person-centered counseling to help consumers, families, and caregivers fully understand the options, including private pay options, that are available to them.
- Streamlined access to publicly supported long-term services and support programs for individuals who appear to be eligible for such programs.
- Outreach and assistance to Medicare beneficiaries on their Medicare benefits, including prevention benefits and low-income subsidies provided as a result of receiving funding under the Medicare Improvements to Patients and Providers Act.

Since 2003, ACL (or its predecessor agencies) and CMS have entered into cooperative agreements with states to develop the infrastructure for these NWD systems. In 2008, the Veterans Health Administration (VHA) also began participating as a key partner. The NWD System framework has also been incorporated in CMS' NWD Medicaid Administrative Guidance as well as AARP's LTSS State Scorecard. The LTSS state scorecard recognizes the NWD System vision as a critical component of a high-performing LTSS access system.

NWD has evolved since its inception and the next era of innovation is building capacity and sustainability. A high-performing NWD system, as defined by the NWD System Key Elements, is continuously improving and is accountable and transparent. In terms of progress, in 2016 and 2019, states completed a detailed self-reported survey fielded by AARP for the NWD System indicator of the LTSS Scorecard. The scorecard found that the median scores improved for each of the NWD System functions.

A sample of results of ADRC/NWD System investments as of FY 2019 include:

- Over 1,322 access points are designated across 56 states, territories, and the District of Columbia. This includes over 676 local area agencies on aging and aging and disability resource centers, 403 centers for independent living, 56 statewide independent living councils, 68 university centers for excellence in developmental disabilities education, research, and service, and 270 tribal organizations.
- Thirty-three states/territories have ADRC/NWD system legislation or gubernatorial support in response to this vision.

- Thirty-one states' NWD systems use standards that define person centered counseling consistent with the requirements in the CMS HCBS Settings Rule (which are identical to those in the "Key Elements of a NWD System of Access to LTSS for All Populations and All Payers").
- Thirty-seven states have a publicly searchable database on a website designed to assist older adults, people with disabilities and their family caregivers to learn about and access public and private LTSS options available in their communities.
- Forty-two states have a toll-free number that connects individuals to trained Information and Assistance Specialists to assist people in need of LTSS.

Aging Network Support Activities
(FY 2019: $17,461,000)

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

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

To help (along with other Federal agencies) ensure that older Americans have access to the highest quality home and community-based services (HCBS) system, the national aging services network must continually enhance program design and delivery in key priority areas. To address this critical need, ACL continued to support a cooperative agreement that is documenting and reporting on area agency on aging and tribal organizations' activities and expertise in the delivery of community-based services through surveys and the highlighting of best practices. Aging Network Support Activities in FY 2019 built upon the lessons learned from the FY 2017 survey and FY 2018 reports of the biannual National Title VI Program Survey: Serving Tribal Elders Across the United States which was released in FY 2018.[128] Additionally, in 2018, the project released several reports identifying issues and barriers AAAs face in addressing key topics, including:

- Rural AAAs: Structure and Services[129]
- Measuring the Value of AAA Services: Making the Case to Health Care Partners[130]

[128] https://www.usaging.org/Files/Title%20VI%20Survey/Title%20VI%20Program%20Survey_508.pdf
[129] https://www.usaging.org/Files/Rural%20AAAs%20Structures%20and%20Services.pdf
[130] https://www.usaging.org/files/n4a_ROI_Report_July2018_Final.pdf

- Supporting America's Aging Prisoner Population: Opportunities & Challenges for Area Agencies on Aging[131]

National Eldercare Locator

In FY 2019, ACL awarded a cooperative agreement in the amount of $2,038,343 to continue operation of the Eldercare Locator. The Eldercare Locator is the only national information and referral resource to provide support to older adults and family caregivers seeking assistance on a wide array of needs related to aging. Through its call center (800-677-1116), which operates five days a week from 9:00 a.m. to 8:00 p.m. Eastern Time, and website (eldercare.acl.gov), the Locator helps consumers navigate the maze of federal, state, and local resources to find the assistance they need. The Eldercare Locator website also contains a geographical search tool and offers users the ability to chat with an information specialist. Older adults and caregivers contact the Locator to find local resources involving a broad range of services including transportation and in-home services and supports. In FY 2019, the volume of phone calls, emails and online chat inquiries to the Eldercare Locator rose to its highest levels ever with 437,373 requests for assistance, an increase from 405,729 in 2018.

In FY 2019, the Eldercare Locator partnered with the University of Southern California Leonard Davis School of Gerontology on the 2019 Home for the Holidays campaign, which focused on home modifications. The national public education campaign included the development of a new brochure, *Modifying Your Home for Healthy Aging* to ensure that older adults and their caregivers are aware of the many services and programs available in communities around the country to support them as they modify their homes for successful aging.[132]

National Alzheimer's Call Center

In FY 2019, ACL awarded a cooperative agreement in the amount of $1,233,571 to continue operation of the National Alzheimer's Call Center. The National Alzheimer's Call Center is a national information and counseling service for persons with Alzheimer's disease, their family members, and informal caregivers. The National Alzheimer's Call Center is available to people in all states, 24 hours a day, seven days a week, 365 days a year to provide expert advice, care consultation, and information and referrals at the national and local levels regarding Alzheimer's disease. Trained professional customer service staff and master's level social workers are always available. In FY 2019, the National Alzheimer's Call Center received 302,979 calls and 34,725 of these calls were escalated for care consultations. Care Consultations are complex calls that are triaged to master's level clinicians for emotional support, problem-solving, care management, caregiver education and crisis intervention as needed.

The National Alzheimer's Call Center provides basic information on caregiving; handling legal issues; resources for long-distance caregiving; and tips for working with the medical community. In FY 2019, the National Alzheimer's Call Center further expanded its channel offering by beginning a pilot of a new Live Chat service. Integrated within the Care and Support pages of

[131] https://www.usaging.org/Files/n4a_AgingPrisoners_23Feb2017REV%20(2).pdf
[132] https://eldercare.acl.gov/Public/Resources/BROCHURES/docs/Home-Modification-Brochure.pdf

alz.org website it allows individuals to communicate in real time with a dementia care expert via chat.

National Education and Resource Center on Women and Retirement Planning

The National Education and Resource Center on Women and Retirement Planning, established in 1998, provides women with access to a one-stop gateway that integrates financial information and resources on retirement, health, and planning for long-term care. This project has made user-friendly financial education and retirement planning tools available to traditionally hard-to-reach women, including low-income women, women of color, women with limited English-speaking proficiency, rural, and other underserved women. Information is offered through financial and retirement planning programs, workshops tailored to meet women's special needs, and publications in hard copy and web-based formats, including materials designed to identify and prevent fraud and financial exploitation of older persons.

In FY 2019, the NRCWR hosted 38 financial education trainings, workshops, exhibits and presentations at events across the country—including at six national aging conferences—reaching more than 9,000 participants with a focus on low and moderate-income women and underserved populations. In FY 2019, ACL awarded the Women's Institute for a Secure Retirement (WISER) $231,525. WISER produced and revised 47 consumer publications, and WISER was featured in 37 media outlets. This includes an interview on caregiving in Women's Health magazine with a circulation of 1.5 million readers, and an interview about older adults and bankruptcy on National Public Radio (NPR)'s national syndicated show "1A with Joshua Johnson" which is carried by 330 stations and is heard by 3.6 million people weekly. A MassMutual "Client Book on Women & Retirement" featuring NRCWR information and resources also reached 1,000 MassMutual advisors.

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 diverse older individuals. In FY 2019, five national non-profit organizations received a total of approximately $1,150,000 for the fourth year of five-year cooperative agreements to continue providing training and technical assistance to professionals serving populations with the greatest social and greatest economic need, as well as to other older consumers and their families.

Each NMAO project develops and pilots practical, community-based interventions for reaching older individuals who experience barriers to accessing home and community-based services. Interventions focus on barriers due to language and low literacy, as well as those directly related to cultural diversity. Strategies developed under this program incorporate the latest technology and facilitate the generation and dissemination of knowledge in forms that can assist diverse older individuals to practice positive health behaviors and strengthen their capacity to maintain active, independent lifestyles.

The NMAO Technical Assistance Centers continued to conduct joint presentations at national, regional, and local aging network events to educate and advocate for their specific member

populations. These presentations reaffirm and expand knowledge about the provision and acceptance of services for all diverse populations and allow for direct discussions and responses with the aging network. Professionals and consumers across the country report that they use products produced to improve program design and implementation, refine service delivery approaches, and enable families to provide care to their elder loved ones for longer periods.

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

In FY 2019, an estimated 100,000 to 120,000 survivors of the Holocaust were living in the United States. The youngest survivors are in their early 70s; however, many are much older and nearly 25 percent of them live in poverty.[133] In FY 2015, Congress appropriated funds "to help provide supportive services for aging Holocaust survivors living in the United States." That same year, ACL issued a funding opportunity intended to build capacity for providing person-centered, trauma informed (PCTI) supportive services for Holocaust survivors and to expand the use of these practices by the broader aging services network with any older adult population who has a history of trauma.

In FY 2019, ACL funded the fifth year of a five-year cooperative agreement of $2.5 million in which the grantee is focusing on two priority areas: 1) advancing innovations in the delivery of PCTI supportive services to Holocaust survivors living in the U.S., while 2) improving the nation's overall capacity to delivery PCTI health and human services for older adults. In FY 2019, Congress appropriated an additional $2.5 million for this program. This supplement is enabling the grantee to continue building on the work already started in previous project periods.

In FY 2019, the fourth year for which data was available from the grantee, the project has reached and served nearly 30,000 individuals, including Holocaust survivors and family caregivers with PCTI services, and has trained approximately 6,000 professionals who work with them in the principles of PCTI services and support. Outcome data continues to show that the interventions piloted by the project are leading to measurable decreases in isolation, loneliness, depression and increases in feelings of safety, security, and independence among survivors, while the family caregivers who are served are reporting reductions in stress. Additionally, many of the techniques developed for use specifically with Holocaust survivors continue to be adapted for use more broadly with other populations of older adults with histories of trauma resulting in greater awareness and understanding of the concept and practice of trauma-informed care in the aging services network.

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

Appendix

Formula Grant Funding Allocations
by State, Territory, and Tribal Organization

Administration for Community Living
Administration on Aging
Department of Health and Human Services

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State/Territory	Supportive Services	Congregate Meals	Home Meals	Preventive Services	NFCSP	Total Title III
Alabama	$5,736,488	$7,392,223	$3,754,854	$372,676	$2,697,024	$19,953,265
Alaska	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
Arizona	$8,335,736	$10,741,697	$5,456,208	$541,537	$4,156,306	$29,231,484
Arkansas	$3,508,869	$4,521,642	$2,296,753	$227,957	$1,702,583	$12,257,804
California	$39,743,944	$51,215,322	$26,014,650	$2,581,998	$18,547,748	$138,103,662
Colorado	$5,699,077	$7,344,014	$3,730,367	$370,245	$2,480,538	$19,624,241
Connecticut	$4,317,097	$5,563,150	$2,825,783	$280,464	$2,087,546	$15,074,040
Delaware	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
District of Columbia	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
Florida	$28,572,320	$36,819,206	$18,702,192	$1,856,225	$14,911,192	$100,861,135
Georgia	$10,258,188	$13,219,030	$6,714,562	$666,432	$4,597,268	$35,455,480
Hawaii	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
Idaho	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
Illinois	$14,029,336	$18,078,652	$9,182,990	$911,427	$6,573,783	$48,776,188
Indiana	$7,396,558	$9,531,442	$4,841,464	$480,524	$3,431,688	$25,681,676
Iowa	$4,085,780	$4,930,575	$2,444,855	$242,656	$1,800,443	$13,504,309
Kansas	$3,291,834	$4,165,239	$2,115,719	$209,989	$1,524,484	$11,307,265
Kentucky	$5,114,777	$6,591,065	$3,347,909	$332,286	$2,360,334	$17,746,371
Louisiana	$5,072,693	$6,536,834	$3,320,363	$329,552	$2,309,022	$17,568,464
Maine	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
Maryland	$6,569,648	$8,465,859	$4,300,205	$426,803	$3,024,970	$22,787,485
Massachusetts	$7,942,180	$10,234,547	$5,198,604	$515,970	$3,761,377	$27,652,678
Michigan	$12,028,499	$15,500,309	$7,873,330	$781,442	$5,568,826	$41,752,406
Minnesota	$6,224,393	$8,020,953	$4,074,216	$404,373	$2,892,508	$21,616,443
Mississippi	$3,317,665	$4,275,249	$2,171,598	$215,535	$1,540,996	$11,521,043
Missouri	$7,183,739	$9,257,196	$4,702,162	$466,698	$3,423,149	$25,032,944
Montana	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
Nebraska	$2,200,628	$2,722,261	$1,382,764	$137,242	$999,483	$7,442,378
Nevada	$3,274,944	$4,220,197	$2,143,635	$212,759	$1,511,606	$11,363,141
New Hampshire	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
New Jersey	$10,179,027	$13,117,020	$6,662,746	$661,289	$4,878,287	$35,498,369
New Mexico	$2,453,623	$3,161,817	$1,606,035	$159,402	$1,150,801	$8,531,678
New York	$23,285,517	$29,026,177	$14,743,749	$1,463,342	$10,817,787	$79,336,572
North Carolina	$11,619,807	$14,973,656	$7,605,818	$754,890	$5,434,085	$40,388,256
North Dakota	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
Ohio	$13,962,632	$17,992,696	$9,139,329	$907,094	$6,534,225	$48,535,976
Oklahoma	$4,303,247	$5,545,302	$2,816,718	$279,564	$2,047,202	$14,992,033
Oregon	$5,054,067	$6,512,832	$3,308,171	$328,342	$2,326,220	$17,529,632
Pennsylvania	$17,145,210	$20,869,802	$10,600,746	$1,052,142	$7,825,257	$57,493,157
Rhode Island	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
South Carolina	$6,116,777	$7,882,275	$4,003,775	$397,382	$2,852,799	$21,253,008
South Dakota	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
Tennessee	$7,697,603	$9,919,378	$5,038,515	$500,081	$3,590,875	$26,746,452
Texas	$25,454,774	$32,801,838	$16,661,584	$1,653,691	$11,473,466	$88,045,353
Utah	$2,441,265	$3,145,892	$1,597,945	$158,599	$1,104,600	$8,448,301
Vermont	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
Virginia	$9,168,569	$11,814,912	$6,001,345	$595,644	$4,247,386	$31,827,856
Washington	$8,110,742	$10,451,763	$5,308,938	$526,921	$3,647,207	$28,045,571
West Virginia	$2,659,561	$3,207,757	$1,621,442	$161,146	$1,168,644	$8,818,550
Wisconsin	$6,889,191	$8,877,632	$4,509,363	$447,562	$3,193,316	$23,917,064
Wyoming	$1,911,839	$2,447,751	$1,242,222	$123,299	$896,526	$6,621,637
American Samoa	$452,907	$577,176	$155,278	$15,412	$112,066	$1,312,839
Guam	$955,920	$1,223,876	$621,111	$61,649	$448,263	$3,310,819
Northern Mariana Islands	$238,980	$305,969	$155,278	$15,412	$112,066	$827,705
Puerto Rico	$4,464,217	$5,751,221	$2,921,314	$290,820	$2,334,663	$15,762,235
Virgin Islands	$955,920	$1,223,876	$621,111	$61,649	$448,263	$3,310,819
TOTAL	**$382,367,856**	**$489,550,292**	**$248,444,380**	**$24,659,710**	**$179,305,190**	**$1,324,327,428**

State/Territory	Ombudsman	Elder Abuse Prevention	Total Title VII
Alabama	$254,425	$76,215	$330,640
Alaska	$84,172	$23,741	$107,913
Arizona	$369,707	$85,675	$455,382
Arkansas	$155,625	$48,157	$203,782
California	$1,762,723	$471,074	$2,233,797
Colorado	$252,765	$58,560	$311,325
Connecticut	$191,472	$59,907	$251,379
Delaware	$84,172	$23,741	$107,913
District of Columbia	$84,172	$23,741	$107,913
Florida	$1,267,239	$344,252	$1,611,491
Georgia	$454,971	$105,407	$560,378
Hawaii	$84,172	$23,741	$107,913
Idaho	$84,172	$23,741	$107,913
Illinois	$622,229	$197,384	$819,613
Indiana	$328,052	$98,224	$426,276
Iowa	$165,661	$55,927	$221,588
Kansas	$143,359	$45,843	$189,202
Kentucky	$226,851	$66,595	$293,446
Louisiana	$224,984	$68,518	$293,502
Maine	$84,172	$23,741	$107,913
Maryland	$291,377	$78,087	$369,464
Massachusetts	$352,251	$109,606	$461,857
Michigan	$533,488	$160,862	$694,350
Minnesota	$276,064	$76,347	$352,411
Mississippi	$147,145	$45,198	$192,343
Missouri	$318,613	$97,643	$416,256
Montana	$84,172	$23,741	$107,913
Nebraska	$93,694	$29,770	$123,464
Nevada	$145,250	$33,651	$178,901
New Hampshire	$84,172	$23,741	$107,913
New Jersey	$451,460	$143,950	$595,410
New Mexico	$108,823	$26,393	$135,216
New York	$999,019	$318,066	$1,317,085
North Carolina	$515,361	$126,782	$642,143
North Dakota	$84,172	$23,741	$107,913
Ohio	$619,270	$197,185	$816,455
Oklahoma	$190,858	$60,208	$251,066
Oregon	$224,158	$56,795	$280,953
Pennsylvania	$718,294	$242,944	$961,238
Rhode Island	$84,172	$23,741	$107,913
South Carolina	$271,291	$63,080	$334,371
South Dakota	$84,172	$23,741	$107,913
Tennessee	$341,404	$91,810	$433,214
Texas	$1,128,970	$274,281	$1,403,251
Utah	$108,275	$25,085	$133,360
Vermont	$84,172	$23,741	$107,913
Virginia	$406,644	$102,820	$509,464
Washington	$359,727	$86,291	$446,018
West Virginia	$109,867	$36,736	$146,603
Wisconsin	$305,549	$90,309	$395,858
Wyoming	$84,172	$23,741	$107,913
American Samoa	$10,521	$2,968	$13,489
Guam	$42,086	$11,870	$53,956
Northern Mariana Islands	$10,521	$2,968	$13,489
Puerto Rico	$197,945	$54,217	$252,162
Virgin Islands	$42,086	$11,870	$53,956
TOTAL	**$16,834,310**	**$4,748,163**	**$21,582,473**

State/Territory	Nutrition Services Incentive Program
Alabama	3,305,548
Alaska	481,849
Arizona	1,830,611
Arkansas	2,398,140
California	13,339,978
Colorado	1,435,191
Connecticut	1,394,074
Delaware	516,431
District of Columbia	826,081
Florida	5,682,172
Georgia	2,741,635
Hawaii	505,007
Idaho	765,510
Illinois	6,939,566
Indiana	1,396,201
Iowa	1,496,973
Kansas	2,107,838
Kentucky	1,535,066
Louisiana	3,492,294
Maine	601,210
Maryland	1,657,806
Massachusetts	5,738,858
Michigan	7,725,865
Minnesota	1,773,889
Mississippi	1,426,940
Missouri	4,029,903
Montana	908,057
Nebraska	1,056,843
Nevada	1,560,287
New Hampshire	1,177,814
New Jersey	3,458,191
New Mexico	2,303,349
New York	16,438,002
North Carolina	3,278,529
North Dakota	791,309
Ohio	5,625,724
Oklahoma	1,819,089
Oregon	1,793,536
Pennsylvania	6,610,409
Rhode Island	403,439
South Carolina	1,785,790
South Dakota	954,326
Tennessee	1,640,636
Texas	11,891,629
Utah	1,283,557
Vermont	777,996
Virginia	1,914,467
Washington	2,362,994
West Virginia	1,514,426
Wisconsin	2,816,751
Wyoming	885,838
American Samoa	84,042
Guam	395,828
Northern Mariana Islands	65,799
Puerto Rico	2,444,490
Virgin Islands	105,969
TOTAL	**$153,293,752**

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP (Cash)
AK	01	Aleutian Pribilof Islands Association, Inc.	$116,280	$44,810	$12,839
AK	02	Association of Village Council Presidents	$148,970	$0	$26,833
AK	03	Bristol Bay Native Association	$148,970	$62,740	$5,900
AK	04	Central Council Tlingit & Haida Indian Tribes of AK	$195,600	$71,700	$2,191
AK	06	Copper River Native Association	$90,860	$26,890	$7,403
AK	07	Hoonah Indian Association	$90,860	$26,890	$1,844
AK	08	Kodiak Area Native Association - Northern Region	$80,080	$17,920	$3,451
AK	09	Kodiak Area Native Association - Southern Region	$80,080	$17,920	$1,523
AK	10	Metlakatla Indian Community	$103,180	$35,850	$18,398
AK	11	Native Village of Barrow	$128,600	$53,790	$12,203
AK	12	Tanana Chiefs Conference for Kuskokwim subregion	$90,860	$26,890	$403
AK	13	Tanana Chiefs Conference for Lower Yukon Subregion	$80,080	$17,920	$4,484
AK	14	Tanana Chiefs Conference for Yukon Flats Subregion	$80,080	$17,920	$403
AK	15	Tanana Chiefs Conference for Yukon Koyukuk Subregion	$90,860	$26,890	$3,113
AK	16	Tanana Chiefs Conference for Yukon Tanana Subregion	$80,080	$17,920	$464
AK	17	Fairbanks Native Association	$148,970	$62,740	$4,555
AK	19	Maniilaq Association	$148,970	$62,740	$21,540
AK	20	Native Villiage of Unalakleet	$90,860	$26,890	$4,731
AK	21	Chugachmiut	$90,860	$26,890	$2,201
AK	22	Arctic Slope Native Association, Limited	$90,860	$26,890	$12,202
AK	23	Denakkanaaga, Inc.	$103,180	$35,850	$432
AK	24	Klawock Cooperative Association	$80,080	$17,920	$1,057
AK	25	Kootznoowoo Inc.	$80,080	$17,920	$2,167
AK	26	Gwichyaa Zhee Gwich'in Tribal Government	$80,080	$17,920	$7,467
AK	27	Native Village of Point Hope	$80,080	$17,920	$3,106
AK	28	Seldovia Village Tribe	$80,080	$17,920	$901
AK	30	Sitka Tribes of Alaska	$116,280	$44,810	$1,378
AK	32	Ketchikan Indian Community	$148,970	$62,740	$6,924
AK	35	Southcentral Foundation	$195,600	$71,700	$22,654
AK	36	Kenaitze Indian Tribe	$148,970	$62,740	$8,495
AK	37	Wrangell Cooperative Association	$90,860	$26,890	$1,092
AK	38	Native Village of Savoonga	$90,860	$26,890	$9,673
AK	39	Native Village of Gambell	$90,860	$26,890	$9,625
AK	40	Native Village of Eyak Traditional Council	$80,080	$17,920	$1,312
AK	41	Organized Village of Kake	$80,080	$17,920	$2,297
AK	42	Chickaloon Native Village	$116,280	$0	$3,356
AK	44	Galena Village (aka Louden Village Council)	$90,860	$26,890	$10,348
AK	45	Asa'carsarmiut Tribe	$80,080	$0	$2,388
AK	46	Orutsararmuit Native Council	$116,280	$44,810	$7,004
AK	47	Chilkoot Indian Association	$90,860	$26,890	$583
AK	48	Knik Tribe	$148,970	$0	$8,760
AK	49	Yakutat Tlingit Tribe	$80,080	$17,920	$1,459
AK	50	Craig Tribal Association	$80,080	$17,920	$1,057
AK	51	Organized Village of Saxman	$80,080	$17,920	$726
		Subtotal	$4,605,670	$1,308,500	$260,942
AL	01	Poarch Band of Creek Indians	$148,970	$62,740	$21,066
		Subtotal	$148,970	$62,740	$21,066
AZ	02	Colorado River Indian Tribes	$148,970	$62,740	$8,713
AZ	03	Gila River Indian Community	$148,970	*$62,740*	$11,917
AZ	04	Hopi Tribe	$148,970	$62,740	$11,828
AZ	05	Hualapai Tribe	$90,860	*$26,890*	$23,313
AZ	06	Navajo Nation	$195,600	$71,700	$37,853

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP (Cash)
AZ	07	Pascua Yaqui Tribe	$148,970	$62,740	$33,579
AZ	09	Salt River Pima-Maricopa Indian Community	$128,600	$53,790	$3,826
AZ	10	San Carlos Apache Older Adult Center	$195,600	$71,700	$8,981
AZ	11	Tohono O'odham Nation	$195,600	$71,700	$9,527
AZ	12	White Mountain Apache Tribe	$195,600	$71,700	$31,297
AZ	13	Ak-Chin Indian Community	$80,080	$0	$5,063
AZ	14	Yavapai-Apache Tribe	$90,860	$0	$5,054
AZ	15	Havasupai Tribe	$90,860	$26,890	$8,438
AZ	16	Inter-Tribal Council of Arizona, Inc.	$90,860	$26,890	$2,341
AZ	17	Cocopah Indian Tribe	$80,080	$0	$14,929
AZ	18	Quechan Indian Tribe	$103,180	$35,850	$14,230
		Subtotal	$2,133,660	$708,070	$230,889
CA	01	Bishop Paiute Tribe	$90,860	$26,890	$14,593
CA	02	Blue Lake Rancheria	$80,080	$17,920	$15,305
CA	06	Karuk Tribe	$103,180	$35,850	$5,643
CA	07	Pit River Health Service, Inc.	$116,280	$0	$5,712
CA	08	Picayune Rancheria of the Chukchansi Indians	$80,080	$17,920	$11,464
CA	09	Riverside-San Bernardino Co. Indian Health-Morongo	$103,180	$35,850	$2,297
CA	10	Riverside-San Bernardino Co. Indian Health-Pechanga	$80,080	$17,920	$2,740
CA	11	Riverside-San Bernardino Co. Indian Health-Soboba/	$80,080	*$17,920*	$5,636
CA	12	Sonoma County Indian Health Project – Sonoma	$80,080	*$0*	$8,542
CA	13	Southern Indian Health Council, Inc. - Area I	$80,080	$17,920	$12,777
CA	14	Southern Indian Health Council, Inc. - Area II	$80,080	$17,920	$11,069
CA	15	Toiyabe Indian Health Project, Inc. – Northern	$80,080	$17,920	$12,588
CA	16	Tule River Indian Health Center, Inc.	$90,860	$26,890	$19,942
CA	17	United Indian Health Services Inc. for Resighini	$103,180	$35,850	$9,950
CA	18	United Indian Health Services Inc. for Tolowa	$148,970	$62,740	$13,236
CA	20	Indian Senior Center, Inc.	$90,860	$26,890	$8,133
CA	21	Sonoma County Indian Health Project – Manchester	$80,080	$0	$5,412
CA	25	Pala Band of Mission Indians	$90,860	$0	$17,311
CA	26	Redding Rancheria	$148,970	$62,740	$6,644
CA	28	Toiyabe Indian Health Project, Inc. – Southern	$80,080	$17,920	$8,022
CA	29	K'ima:w Medical Center	$103,180	$0	$10,416
CA	30	Round Valley Indian Tribes Senior Center	$90,860	$0	$13,348
CA	31	Fort Mojave Indian Tribe	$90,860	$26,890	$10,424
CA	33	CA Indian Manpower Consortium, Inc. - Chico,	$80,080	$17,920	$2,545
CA	34	CA Indian Manpower Consortium, Inc. - Big Sandy,	$90,860	$26,890	$7,291
CA	35	CA Indian Manpower Consortium, Inc. - Berry Creek,	$90,860	$26,890	$3,188
CA	36	CA Indian Manpower Consortium, Inc. - Coyote Valley,	$90,860	$26,890	$3,091
CA	37	CA Indian Manpower Consortium, Inc. - Enterprise,	$103,180	$35,850	$4,674
CA	38	Santa Ynez Tribal Health Clinic	$80,080	$0	$11,128
CA	39	CA Indian Manpower Consortium, Inc. - North Fork,	$80,080	$17,920	$5,346
CA	40	CA Indian Manpower Consortium, Inc. - Robinson,	$80,080	$17,920	$1,879
CA	41	Wilton Rancheria	$80,080	$0	$1,616
CA	42	Wiyot Tribe	$90,860	$26,890	$986
		Subtotal	$3,039,920	$681,120	$272,948
CO	01	Southern Ute Indian Tribe	$103,180	$35,850	$5,365
CO	02	Ute Mountain Ute Tribe	$90,860	$0	$10,939
		Subtotal	$194,040	$35,850	$16,304
CT	01	Mohegan Tribe of Indians of Connecticut	$90,860	$0	$2,154
CT	02	Mashantucket Pequot Tribal Nation	$80,080	$0	$719
		Subtotal	$170,940	$0	$2,873
HI	01	Alu Like, Inc.	$1,505,000	$71,700	$28,652

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP (Cash)
		Subtotal	$1,505,000	$71,700	$28,652
IA	01	Sac & Fox Tribe of the Mississippi in Iowa	$90,860	$26,890	$11,554
		Subtotal	$90,860	$26,890	$11,554
ID	01	Coeur d'Alene Tribe	$90,860	$26,890	$34,670
ID	02	Nez Perce Tribe	$148,970	$62,740	$31,265
ID	03	Shoshone-Bannock Tribes	$128,600	$53,790	$20,203
		Subtotal	$368,430	$143,420	$86,138
KS	01	Kickapoo Tribe in Kansas	$90,860	*$26,890*	$10,552
KS	02	Prairie Band Potawatomi Nation	$103,180	$35,850	$30,441
KS	03	Iowa Tribe of Kansas and Nebraska	$80,080	$17,920	$7,030
		Subtotal	$274,120	$80,660	$48,023
LA	01	Institute for Indian Development, Inc.	$116,280	$0	$17,372
		Subtotal	$116,280	$0	$17,372
MA	01	Wampanoag Tribe of Gay Head (Aquinnah)	$90,860	*$26,890*	$1,063
MA	02	Mashpee Wampanoag Tribe	$116,280	$44,810	$4,865
		Subtotal	$207,140	$71,700	$5,928
ME	01	Pleasant Point Passamaquoddy	$103,180	$35,850	$34,283
ME	02	Penobscot Indian Nation	$90,860	$0	$4,731
ME	04	Aroostook Band of Micmacs	$90,860	*$26,890*	$12,947
		Subtotal	$284,900	*$62,740*	$51,961
MI	01	Grand Traverse Band of Ottawa & Chippewa Indians	$103,180	$35,850	$9,630
MI	02	Inter-Tribal Council of Michigan, Inc.	$90,860	$26,890	$6,154
MI	03	Keweenaw Bay Indian Community	$103,180	*$35,850*	$18,875
MI	04	Sault Ste. Marie Tribe of Chippewa Indians	$195,600	*$0*	$20,808
MI	05	Little Traverse Bay Bands of Odawa Indians	$128,600	$53,790	$4,338
MI	07	Bay Mills Indian Community	$90,860	$26,890	$6,825
MI	08	Pokagon Band of Potawatomi Indians	$103,180	$0	$4,713
MI	09	Little River Band of Ottawa Indians	$116,280	$44,810	$10,083
MI	10	Nottawaseppi Huron Band of the Potawatomi	$80,080	*$0*	$620
		Subtotal	$1,011,820	*$224,080*	$82,046
MN	01	Bois Forte Band of Chippewa	$90,860	*$26,890*	$11,054
MN	02	Fond du Lac Band of Lake Superior Chippewa	$148,970	$62,740	$48,992
MN	03	Leech Lake Band of Ojibwe	$148,970	$62,740	$34,535
MN	07	Red Lake Band of Chippewa Indians	$148,970	$0	$61,155
MN	08	White Earth Reservation Tribal Council	$148,970	*$62,740*	$17,230
MN	09	Grand Portage Band of Lake Superior Chippewa	$80,080	$17,920	$5,737
MN	10	Mille Lacs Band of Ojibwe	$90,860	$26,890	$18,654
MN	11	Lower Sioux Indian Community	$80,080	$17,920	$7,102
		Subtotal	$937,760	$277,840	$204,459
MS	01	Mississippi Band of Choctaw Indians	$148,970	$62,740	$22,737
		Subtotal	$148,970	$62,740	$22,737
MT	01	Fort Peck Assiniboine and Sioux Tribes	$148,970	$62,740	$46,989
MT	02	Blackfeet Tribe - Eagle Shield Center	$148,970	$62,740	$26,110
MT	03	Chippewa Cree Tribe Senior Citizens Department	$116,280	$44,810	$12,406
MT	04	Confederated Salish and Kootenai Tribes	$148,970	$62,740	$3,985
MT	05	Fort Belknap Indian Community	$116,280	$44,810	$17,863
MT	06	Northern Cheyenne Elderly Program	$128,600	$53,790	$18,937
MT	07	Crow Tribal Elders Program	$148,970	$62,740	$28,428
		Subtotal	$957,040	$394,370	$154,718
NC	01	Eastern Band of Cherokee Indians	$195,600	$71,700	$27,679
		Subtotal	$195,600	$71,700	$27,679
ND	01	Spirit Lake Tribe	$103,180	$35,850	$55,909

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP (Cash)
ND	02	Standing Rock Sioux Tribe	$148,970	$62,740	$58,288
ND	03	Three Affiliated Tribes	$148,970	$62,740	$29,428
ND	04	Trenton Indian Service Area	$103,180	$35,850	$1,507
ND	05	Turtle Mountain Band of Chippewa Indians	$148,970	$62,740	$18,521
		Subtotal	$653,270	$259,920	$163,653
NE	01	Omaha Tribe of Nebraska	$90,860	*$26,890*	$9,632
NE	02	Santee Sioux Nation	$80,080	*$0*	$4,947
NE	03	Winnebago Senior Citizen Center	$90,860	$26,890	$14,876
NE	04	Ponca Tribe of Nebraska	$80,080	*$17,920*	$0
		Subtotal	$341,880	*$71,700*	$29,455
NM	01	Eight Northern Indian Pueblos Council, Inc. (Picuris, etc.)	$195,600	$71,700	$26,864
NM	02	Eight Northern Indian Pueblos Council, Inc. (San	$116,280	$44,810	$4,552
NM	03	Five Sandoval Indian Pueblos, Inc.	$116,280	$44,810	$8,726
NM	04	Jicarilla Apache Nation	$128,600	$53,790	$23,868
NM	05	Laguna Rainbow Corporation	$195,600	$71,700	$20,842
NM	06	Mescalero Apache Tribe Elderly Program	$116,280	$0	$10,998
NM	07	Pueblo de Cochiti Elder Program	$90,860	$26,890	$8,288
NM	09	Pueblo of Isleta Elder Center	$148,970	*$62,740*	$24,375
NM	10	Pueblo of Jemez Senior Citizens Program	$148,970	$62,740	$8,990
NM	11	Pueblo of San Felipe Elderly Services Program	$148,970	*$62,740*	$38,483
NM	12	Taos Pueblo Senior Citizens Program	$103,180	$35,850	$7,851
NM	13	Zuni Tribe	$195,600	$71,700	$27,263
NM	14	Ohkay Owingeh Senior Citizens Program	$148,970	$62,740	$16,738
NM	15	Santa Clara Pueblo Senior Center	$148,970	$62,740	$17,115
NM	16	Santo Domingo Tribe	$148,970	$62,740	$14,456
NM	17	Pueblo of Tesuque	$80,080	*$17,920*	$7,207
NM	18	Pueblo of Acoma	$116,280	$44,810	$10,493
		Subtotal	$2,348,460	$860,420	$277,109
NV	01	Fallon Paiute-Shoshone Tribes	$90,860	$26,890	$21,470
NV	02	Inter-Tribal Council of Nevada, Inc. (McDermitt, etc.)	$80,080	$17,920	$5,845
NV	03	Inter-Tribal Council of Nevada, Inc. (Duckwater, etc.)	$80,080	*$17,920*	$7,446
NV	04	Inter-Tribal Council of Nevada, Inc. (Ely, etc.)	$80,080	$17,920	$4,574
NV	05	Shoshone-Paiute Tribes	$116,280	$44,810	$8,688
NV	06	Walker River Paiute Tribe	$90,860	$26,890	$9,415
NV	07	Washoe Tribe of Nevada and California	$90,860	$26,890	$14,483
NV	08	Yerington Paiute Tribe	$80,080	$17,920	$5,248
NV	09	Pyramid Lake Paiute Tribe	$90,860	$26,890	$8,572
NV	10	Elko Band Council	$90,860	$26,890	$6,290
NV	11	Reno-Sparks Indian Colony	$90,860	$26,890	$15,673
		Subtotal	$981,760	$277,830	$107,704
NY	01	Saint Regis Mohawk Tribe	$148,970	$62,740	$6,046
NY	02	Seneca Nation Area Office for the Aging	$148,970	$62,740	$19,798
NY	04	Oneida Indian Nation Elders Program	$90,860	$26,890	$5,786
NY	05	Shinnecock Indian Nation	$90,860	$26,890	$3,944
		Subtotal	$479,660	$179,260	$35,574
OK	01	Apache Tribe of Oklahoma	$90,860	$26,890	$22,128
OK	02	Caddo Nation of Oklahoma	$80,080	$17,920	$4,587
OK	03	Cherokee Nation	$196,643	$72,943	$37,277
OK	04	Cheyenne and Arapaho Tribes of Oklahoma	$148,970	$62,740	$10,286
OK	06	Choctaw Nation of Oklahoma	$195,600	*$71,700*	$46,665
OK	07	Citizen Potawatomi Nation	$195,600	$71,700	$11,258
OK	08	Comanche Nation	$148,970	$62,740	$19,330
OK	09	Delaware Nation	$80,080	$17,920	$4,393

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP (Cash)
OK	10	Iowa Tribe of Oklahoma	$148,970	$62,740	$9,353
OK	12	Kickapoo Tribe of Oklahoma	$100,000	$26,890	$10,993
OK	13	Kiowa Tribe of Oklahoma	$195,600	$71,700	$15,179
OK	14	Miami Tribe of Oklahoma	$148,970	$62,740	$31,819
OK	15	Muscogee Creek Nation Elderly Nutrition Program	$195,600	$71,700	$92,255
OK	18	Ottawa Tribe of Oklahoma	$148,970	$62,740	$25,865
OK	19	Pawnee Nation of Oklahoma	$116,280	$44,810	$10,630
OK	20	Peoria Tribe of Indians of Oklahoma	$128,600	$53,790	$10,758
OK	21	Ponca Tribe of Indians of Oklahoma	$116,280	*$44,810*	$16,611
OK	22	Quapaw Tribe Elders Center	$148,970	$62,740	$26,212
OK	23	Sac and Fox Nation of Oklahoma	$148,970	$62,740	$14,146
OK	24	Seminole Nation of Oklahoma	$148,970	$62,740	$14,583
OK	25	Seneca-Cayuga Nation	$90,860	$26,890	$11,075
OK	26	Wichita and Affiliated Tribes	$148,970	*$62,740*	$10,129
OK	27	Wyandotte Nation	$148,970	$62,740	$19,290
OK	28	Absentee Shawnee Tribe of Oklahoma	$195,600	$71,700	$30,134
OK	29	Fort Sill Apache Tribe	$116,280	$44,810	$6,539
OK	31	United Keetoowah Band of Cherokee Indians	$195,600	$71,700	$23,530
OK	32	Chickasaw Nation	$195,600	$71,700	$124,539
OK	33	Kaw Nation	$80,080	$0	$21,667
OK	34	Osage Nation	$148,970	$62,740	$66,857
OK	35	Delaware Tribes of Indians	$195,600	$71,700	$11,328
OK	36	Alabama-Quassarte Tribal Town	$80,080	$17,920	$14,316
OK	37	Eastern Shawnee Tribe of Oklahoma	$128,600	$53,790	$20,622
OK	38	Otoe-Missouria Tribe of Indians	$90,860	$26,890	$9,529
		Subtotal	$4,699,053	$1,740,013	$803,883
OR	01	Confederated Tribes of Siletz Indians	$128,600	$53,790	$2,394
OR	02	Yellowhawk Tribal Health Center	$128,600	$53,790	$10,950
OR	03	Confederated Tribes of Warm Springs	$148,970	$62,740	$8,915
OR	04	Confederated Tribes of Grand Ronde	$116,280	$44,810	$25,471
OR	05	The Klamath Tribes	$148,970	$62,740	$3,976
OR	06	Confed. Tribes of Coos, Lower Umpqua &	$103,180	$35,850	$10,557
OR	07	Cow Creek Band of Umpqua Tribe of Indians	$90,860	$26,890	$1,693
		Subtotal	$865,460	$340,610	$63,956
RI	01	Narragansett Indian Tribe	$116,280	$44,810	$2,295
		Subtotal	$116,280	$44,810	$2,295
SC	01	Catawba Indian Nation	$116,280	$44,810	$14,108
SD	01	Cheyenne River Elderly Nutrition Services	$148,970	$62,740	$13,606
SD	02	Crow Creek Sioux Tribe	$90,860	$0	$16,987
SD	03	Lower Brule Sioux Tribe	$90,860	$26,890	$17,865
SD	04	Oglala Sioux Tribe	$195,600	$71,700	$47,472
SD	05	Rosebud Sioux Tribe	$195,600	$71,700	$35,130
SD	06	Sisseton Wahpeton Oyate of the	$148,970	$62,740	$22,590
SD	08	Yankton Sioux Tribe	$128,600	$53,790	$29,913
		Subtotal	$1,115,740	$394,370	$197,671
TX	01	Alabama-Coushatta Tribe of Texas	$90,860	$26,890	$804
TX	02	Kickapoo Traditional Tribe of Texas	$80,080	$0	$17,680
		Subtotal	$170,940	$26,890	$18,484
UT	01	Unitah & Ouray, Ute Indian Tribe	$116,280	*$44,810*	$9,331
		Subtotal	$116,280	*$44,810*	$9,331
WA	01	Confederated Tribes of the Colville Reservation	$148,970	$62,740	$22,932
WA	02	Lower Elwha Klallam Tribe	$80,080	$17,920	$10,833
WA	03	Lummi Nation	$116,280	$44,810	$16,693

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP (Cash)
WA	04	Makah Tribe Senior Program	$90,860	$26,890	$11,211
WA	05	Muckleshoot Indian Tribe	$148,970	$62,740	$36,326
WA	09	Puyallup Tribe of Indians	$195,600	$0	$13,021
WA	10	Quinault Indian Nation	$103,180	$35,850	$45,910
WA	13	Swinomish Indian Tribal Community	$90,860	*$26,890*	$8,675
WA	14	Spokane Tribes of Indians	$90,860	$26,890	$14,630
WA	16	The Tulalip Tribes of Washington	$195,600	*$71,700*	$13,551
WA	17	Jamestown S'Klallam Tribe	$90,860	$26,890	$10,137
WA	19	Quileute Tribe	$80,080	*$17,920*	$4,601
WA	20	S. Puget Intertribal Planning Agency - Shoalwater Bay	$103,180	$35,850	$5,498
WA	22	Upper Skagit Indian Tribe	$80,080	$17,920	$2,052
WA	24	Suquamish Indian Tribe of the	$103,180	$35,850	$8,591
WA	25	Port Gamble S'Klallam Tribe	$90,860	$26,890	$6,150
WA	26	Samish Indian Nation / Sauk Suiattle Tribal Consortium	$116,280	$44,810	$1,346
WA	27	Cowlitz Indian Tribe	$195,600	$71,700	$5,536
WA	28	Skokomish Indian Tribe	$103,180	$35,850	$1,920
WA	29	Confederated Tribes of the Chehalis Reservation	$148,970	*$62,740*	$6,839
WA	30	Nooksack Indian Tribe	$90,860	$26,890	$3,917
WA	31	Yakama Nation	$148,970	$62,740	$2,113
WA	32	Snoqualmie Indian Tribe	$80,080	*$17,920*	$1,799
WA	33	S. Puget Intertribal Planning Agency – Nisqually	$148,970	$62,740	$3,883
WA	34	Squaxin Island Tribe	$116,280	*$44,810*	$4,909
WA	35	Sauk-Suiattle Indian Tribe	$80,080	$17,920	$4,235
		Subtotal	$3,038,770	$985,870	$267,308
WI	01	Bad River Elderly Program	$90,860	$26,890	$11,897
WI	02	Forest County Potawatomi Community	$80,080	$17,920	$11,103
WI	03	Lac Courte Oreilles Band of Lake Superior Chippewa	$116,280	$44,810	$7,910
WI	04	Lac du Flambeau Band of Lake Superior Chippewa	$103,180	$35,850	$21,724
WI	05	Menominee Indian Tribe of Wisconsin	$148,970	$62,740	$4,791
WI	06	Oneida Nation Elder Services	$148,970	$62,740	$10,048
WI	07	Red Cliff Band of Lake Superior Chippewa	$90,860	$26,890	$18,482
WI	08	St. Croix Chippewa Indians of Wisconsin	$90,860	$26,890	$8,418
WI	09	Stockbridge-Munsee Community	$90,860	$26,890	$2,589
WI	10	Ho-Chunk Nation	$128,600	$53,790	$15,680
WI	11	Sokaogon Chippewa Community (SCC)	$80,080	$17,920	$4,496
Subtotal			$1,169,600	$403,330	$117,138
WY	01	Northern Arapaho Tribe	$148,970	$0	$17,389
WY	03	Eastern Shoshone Tribe	$116,280	$0	$11,892
Subtotal			$265,250	$0	$29,281
Total			$32,753,523	$9,913,953	$42,667,476