108TH CONGRESS
2nd Session

SENATE

REPT. 108–265
Volume 2

DEVELOPMENTS IN AGING: 2001 AND 2002
VOLUME 2

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 66, SEC. 17(c), FEBRUARY 26, 2003

Resolution Authorizing a Study of the Problems of the Aged and Aging

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DEVELOPMENTS IN AGING: 2001 AND 2002—VOLUME 2

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING
Washington, DC, 2004.

Hon. DICK CHENEY,
President, U.S. Senate,
Washington, DC.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 66 agreed to February 26, 2003, I am submitting to you the annual report of the U.S. Senate Special Committee on Aging, Developments in Aging: 2001 and 2002, volume 2.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions taken during 2001 and 2002 by the Congress, the administration, and the U.S. Senate Special Committee on Aging, which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons and their families.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

LARRY CRAIG, *Chairman.*

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Mr. CRAIG, from the Special Committee on Aging, submitted the following

REPORT

REPORT FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1—AGRICULTURE

U.S. Department of Agriculture (USDA) agencies assist older Americans through a number of programs in areas such as housing; community facilities and services; health care; food safety education; food assistance; diet, nutrition, and health research; and use of information technology for lifelong learning. These agencies and their programs are highlighted below.

RURAL HOUSING SERVICE

Programs of USDA's Rural Housing Service (RHS) of interest to older people and their families include those dealing with housing, community facilities, and rural economic development.

MULTI-FAMILY HOUSING

USDA's Rural Housing Service offers several programs that provide funding for rental properties intended for very low-, low-, and moderate-income rural residents. More than $11.9 billion in subsidized credit has been provided to developers of affordable rental housing. Two programs serve older American communities: the Section 515 Rural Rental Housing program and the Section 538 program.

The Section 515 Rural Rental Housing (RRH) program was implemented in 1962 by the signing of the Senior Citizen Housing Act of 1962 (Public Law 87–723). The purpose of this program is to provide affordable rental housing for rural families and older people

who have very low to moderate incomes. The RRH program also provides funds to build congregate housing and group homes, recognizing that the housing needs of older Americans change as they get older. Properties built for older Americans typically contain community rooms where the delivery of services at the property may be accomplished. In most instances, the Section 515 RRH program is responsible for the bulk of affordable rental housing in small towns. The program allows older Americans the opportunity to remain in their communities, close to family and friends.

In fiscal year (FY) 2002, RHS provided more than 176,000 rental assistance units for older Americans, and funding for renewals of rental assistance for older Americans exceeded $225 million. A total of 72 new rental assistance units were available in FY 2002 to older Americans.

RHS continues to increase outreach efforts to aid rural older Americans. An existing Memorandum of Understanding with the Administration on Aging currently is being amended to put greater emphasis on ensuring that the physical, mental, and emotional needs of older Americans residing in Multi-Family Housing complexes are met.

The Multi-Family Housing section also appreciates the site managers of the complexes that are in the portfolio. Each year in both the family and elderly categories, site managers are nominated for the Site Manager of the Year award. In FY 2002, because of a tie, two site managers of elderly complexes received this award. The selection is based upon tenant satisfaction with the manager; the curb appeal of the property; accurate and complete record keeping, with no incidents of noncompliance; and whether the actions of the manager are consistently above and beyond what is required.

The Section 538 program was first authorized in 1996. It provides guarantees to private and public lenders for loans made to developers of rental housing in rural areas. The program does not have deep tenant subsidies, and therefore the primary beneficiaries are low- and moderate-income rural residents. A significant segment of seniors has incomes that are too high for many affordable housing programs, yet too low to access market rate housing in appreciating markets. The Section 538 program provides a solution to this problem.

In June 2001, the Agency entered into a Memorandum of Understanding with Freddie Mac, allowing Freddie Mac to partner in the development of a secondary market for the program. To date, the program has guaranteed funds to partner in the development of 2,285 units, with another 4,261 expected to be built.

COMMUNITY FACILITIES DIRECT LOAN PROGRAM

The Community Facilities Direct Loan Program provides loans to public bodies, Indian tribes, and nonprofit corporations to assist eligible rural communities in providing essential community facilities and services to citizens. Many of these loans provide facilities and services to older rural Americans. Funded projects that primarily provide assistance to older Americans are listed below.

In 2001, the Agency provided direct loan financing for:

- Ten nursing homes, totaling $23,283,600
- Twenty-two assisted living facilities, totaling $13,650,600
- Twenty-one hospitals, totaling $32,206,700
- Eight rehabilitation centers, totaling $3,233,650
- Five medical office buildings, totaling $3,972,000
- Three adult day care centers, totaling $492,300
- Six special transportation vehicles, totaling $1,164,880

In 2002, the Agency provided direct loan financing for:

- Ten nursing homes, totaling $14,453,000
- Seventeen assisted living facilities, totaling $9,786,500
- Twenty-two hospitals, totaling $50,500,150
- Two rehabilitation centers, totaling $3,325,000
- Eight medical office buildings, totaling $8,518,700
- Four adult day care centers, totaling $610,970
- Two special transportation vehicles, totaling $551,000

COMMUNITY FACILITIES GRANT PROGRAM

The Community Facilities Grant Program makes grants to eligible public bodies, Indian tribes, and nonprofit applicants to assist in providing essential community facilities and services to residents. These are made as both stand-alone grants and in coordination with direct loans. Funded projects that primarily provide assistance to older Americans are listed below.

In 2001, the Agency provided grant funds for:

- Five nursing homes, totaling $295,410
- Five assisted living facilities, totaling $474,970
- Eight hospitals, totaling $741,180
- One rehabilitation center for $52,700
- Three medical office buildings, totaling $707,500
- Four adult day care centers, totaling $128,650
- Thirteen special transportation vehicles, totaling $379,650

In 2002, the Agency provided grant funds for:

- Four assisted living facilities, totaling $172,900
- Eleven hospitals, totaling $692,420
- Three rehabilitation centers, totaling $209,770
- Three medical office buildings, totaling $2,761,400
- Six adult day care centers, totaling $285,605
- Five special transportation vehicles, totaling $95,470

COMMUNITY FACILITIES GUARANTEED LOAN PROGRAM

The Community Facilities Guaranteed Loan Program provides loan guarantees on loans provided by other lenders to eligible public entities, Indian tribes, and nonprofit applicants to finance essential community facilities and services in eligible rural areas. Guaranteed loan projects of substantial interest to aging Americans are listed below.

In 2001, the Agency provided loan guarantees for the following:

- Five nursing homes, totaling $8,520,000
- Nine assisted living facilities, totaling $7,657,000
- Ten hospitals, totaling $22,850,000
- One rehabilitation center for $650,000
- Two medical office buildings, totaling $800,000

In 2002, the Agency provided loan guarantees for the following:

- Four nursing homes, totaling $2,475,000
- Four assisted living centers, totaling $3,945,000

- Eight hospitals, totaling $12,821,815
- Two rehabilitation centers, totaling $400,000
- Three medical office buildings, totaling $1,791,750

ECONOMIC IMPACT INITIATIVE GRANT PROGRAM

The Economic Impact Initiative Grant Program is a special allocation program that provides grants to eligible rural areas with extreme economic depression. Extreme economic depression is defined as a community having a Department of Labor ″not employed″ rate of 19.5 percent or greater. Eligible applicants compete nationally for funds. Those funded projects that primarily affect older Americans are listed below.

In 2001, the Agency provided funds for:

- Two nursing homes, totaling $263,000
- One boarding home for the elderly for $402,210
- Two assisted living facilities, totaling $417,000
- One hospital, totaling $50,000
- One medical office building for $591,000
- One food preparation distribution center for $75,000
- One planning grant for a nursing home of $16,500

In 2002, the Agency provided funds for:

- Two assisted living facilities, totaling $133,900
- Four hospitals, totaling $345,000
- Two medical office buildings, totaling $2,661,400
- Four adult day care centers, totaling $265,605
- Two food preparation distribution centers, totaling $71,600

SPECIAL DISASTER COMMUNITY FACILITIES LOAN AND GRANT PROGRAMS (LIMITED TO AREAS OF NORTH CAROLINA AFFECTED BY HURRICANES DENNIS, FLOYD, AND IRENE)

Under a special funding allocation, the Agency provided direct loans and grants to assist in rebuilding eligible rural communities in North Carolina damaged by Hurricanes Dennis, Floyd, and Irene. The funded projects that assisted aging Americans in rural North Carolina are listed below.

In 2001, the Agency made loans and grants as follows:

- One nursing home grant for $8,000
- Four hospital loans totaling $7,609,500 and three grants totaling $440,000
- Two adult day care loans totaling $235,000 and one grant for $20,000
- One special transportation vehicle loan for $62,180 and three grants totaling $80,250

In 2002, the Agency made loans and grants as follows:

- One hospital grant for $87,500
- One rehabilitation loan for $2,725,000 and one grant for $200,000
- One medical office building loan for $886,000 and one grant for $100,000

RURAL COMMUNITY DEVELOPMENT INITIATIVE-HOME-BASED HEALTH CARE COOPERATIVE PROJECT

The Community Programs section is offering a new home health care demonstration program, currently under development, to en-

courage the establishment of home health care provider cooperatives. The goal of the program is to promote the creation of home health care service models that will improve working conditions for service providers, increase workforce stability, and establish new ideas for home health care services.

Part One of the project is for preplanning grants to promote and develop home health care provider cooperatives. These grants will be awarded to eligible nonprofit organizations and public bodies. Competition will be at the national level.

Part Two of the project is for grants to establish and fund revolving loans that will be awarded to eligible nonprofit organizations or public bodies to provide technical assistance to preplanning grantees and the cooperatives created from this program. The grantees also will process and administer revolving loans to these cooperatives for their start-up and operating costs. Competition will occur at the national level.

SINGLE FAMILY HOUSING

RHS offers a grant program exclusively for homeowners over the age of 62 to help them make essential repairs to their homes. The Section 504 Home Repair grant program began serving elderly, limited-income households in 1950. Since that time, the program has provided more than one-half billion dollars to allow more than 130,000 older rural Americans to remain in their own-decent-homes.

Section 504 grant funds may be used only to pay for essential repairs or improvements that remove health and safety hazards or improve access. Eligible homeowners must live in an eligible rural area and must have a Very Low Income (less than 50 percent of the median for the area). They must be unable to afford a loan from RHS or other sources. Funds are most often used for replacing roofs, updating unsafe electrical systems, installing furnaces, and providing features such as wheelchair ramps and easily accessible bathrooms.

The program provides assistance to rural residents with great need who are often seeking help for the first time. The average income of households receiving grants in FY 2002 was less than $8,900.

Women and minorities receive a substantial share of the Section 504 grants. More than two-thirds (69.3 percent in FY 2001, the latest year for which data are available) of the grantees are women. Many are widowed. A total of 38 percent of those receiving grants in FY 2002 were minorities. This compares to a rural minority population of 13.2 percent. (Note: This is based on the U.S. Census Bureau definition of "rural." "Minority" includes all persons, except those "white, not Hispanic or Latino," as reported by Census 2000.)

FOOD SAFETY AND INSPECTION SERVICE

USDA's Food Safety and Inspection Service (FSIS) provides food safety education and advice that is designed to address the needs and concerns of older Americans. A variety of educational approaches are used to reach this group.

EDUCATIONAL PROGRAM FOR SENIORS

In 2001 and 2002, the Food Safety and Inspection Service continued distribution of a unique consumer publication and companion video tailored to the needs of seniors. Developed jointly with the Food and Drug Administration, ″To Your Health, Food Safety for Seniors″ targets behaviors most likely to result in foodborne illness in seniors. It also provides basic information on safe food handling, including refrigerator storage charts and cooking temperature charts.

The four-color, 17-page publication is printed in large (14-point) type and is designed to be read easily by older eyes. The format and presentation were developed with guidance from AARP and the National Institutes of Health.

Since its release in 2000, approximately 500,000 copies of this publication and 50,000 copies of the video have been distributed. The document also is accessible on the Internet (http://www.foodsafety.gov/fsg/sr2.html). Printed copies are available in Spanish.

ONGOING FOOD SAFETY ADVICE FOR SENIORS

To help communicate the importance of safe food handling for seniors, all news releases issued by FSIS include a boxed feature with safe food handling advice for at-risk audiences. The Food Safety Education staff also develops special features and fact sheets designed to help educate seniors about safe food handling. These materials can be accessed on the Internet (http://www.fsis.usda.gov/OA/pubs/consumerpubs.htm).

COOPERATIVE STATE RESEARCH, EDUCATION, AND EXTENSION SERVICE

The Cooperative State Research, Education, and Extension Service (CSREES) has provided $4.5 million to fund a project that represents the first multi-site, long term study to document- concurrently-the safety, effectiveness, and optimal dosage of soy isoflavone supplementation to prevent bone loss in postmenopausal women. The project will provide consumers and their primary care physicians with science based information to enable them to make an informed decision on the use of a dietary supplement to prevent osteoporosis. Preventing osteoporosis will, in turn, help to reduce health care costs.

With approximately 20 million American women already afflicted with osteoporosis and approximately 76 million baby boomers reaching 50, the total cost of U.S. health care is projected to surpass $16 trillion in 2030. This phenomenal health care cost is driven largely by the expense of caring for older Americans who have lost the ability to live independently. Osteoporosis is among the major causes of loss of independence.

Although hormone replacement therapy has been shown to be effective in reducing the risk of bone fracture, prolonged usage has been documented to increase the risks of breast cancer, endometrial cancer, and ovarian cancer. Soy isoflavones, with chemical structures similar to specific estrogen receptor modulators such as tamoxifen, have been shown to reduce bone loss in short term studies.

Over the last 4 years, CSREES has supported studies of the prevention of degenerative diseases typically experienced by older Americans. A pair of projects at Kansas State University and one at the University of Maryland focused on the eye. Two projects tested the theory that increased antioxidant consumption reduces the incidence of age-related macular degeneration. The other examined how the eye repairs itself with an enzyme, protein kinase C gamma. This work has important implications for persons with diabetes, who are at increased risk of cataracts and blindness.

Seniors in rural communities, where health resources are growing scarcer, are doing online assessments of their personal health situations. This Internet-based research helps seniors compare health behaviors identified by the U.S. Department of Health and Human Services with self-administered health profiles using the Internet. The research project is being supported by CSREES and the National Library of Medicine, working with State and local Cooperative Extension educators and 4 H youth who help seniors use the Internet-based health assessment and outreach system CyberHealth as well as with CyberSeniors.org. Early results suggest that senior and youth health behaviors are being influenced positively by participation in CyberHealth training.

A program called CyberSeniors CyberTeens, sponsored by USDA, has helped thousands of seniors learn to use information technology to improve family communications and to provide access to lifelong learning through the Internet. The initial program originated with youth teaching seniors. Now 20,000 seniors and youth make up Tech Teams that teach others in their communities to learn to use computers and the Internet. CSREES has provided national leadership to public-, private-, and nonprofit-sector partners, with "tech-savvy" 4 H members in 21 States and American Samoa. National 4 H, USDA, the Department of Health and Human Services, the Department of Veterans Affairs, AARP, and CyberSeniors.org have partnered to build the CyberSeniors CyberTeens Intergenerational CyberSkills partnership.

CSREES supported a "Nutrition and Health Information Survey" that was pilot tested, administered, and analyzed by the Pennsylvania State University Survey Research Center to assess (1) how nutrition and health resources and information reach the elderly in Appalachia and (2) attitudes of elderly persons toward nutrition/health and nutrition/health education. The information from this venture soon will be presented in national nutrition/health conferences for consideration by similar communities. This information also will be offered for publication in food, nutrition, and health journals.

AGRICULTURAL MARKETING SERVICE

The Agricultural Marketing Services facilitates the accessibility of agricultural products to older Americans by promoting and developing wholesale, collection, farmers, and direct markets. The support provided for these markets has made fresh, nutritious foods available in communities where older Americans previously have not had access to such products. The number of farmers markets has increased from 1,755 in 1994 to more than 3,147 in 2003.

ECONOMIC RESEARCH SERVICE

The Economic Research Service (ERS) identifies research and policy issues relevant to the elderly population from the perspective of rural development. Ongoing research looks at demographic and socioeconomic characteristics of the older population by rural-urban residence. Current research examines rural-urban differences in health and access to health care for the elderly, based on data from the Current Population Survey and National Health Interview Survey. In the past year, ERS participated in the Interagency Forum on Aging-Related Statistics and reviewed proposals for the Office of Rural Health Policy's Rural Health Analytic Research Center Cooperative Agreement Program.

PUBLICATIONS ON THE ELDERLY IN RURAL AMERICA

ERS released the following publications on issues faced by older Americans in rural America:

Fugitt, Glenn V., Calvin L. Beale, and Stephen J. Tordell. "Recent Trends in Older Population Change and Migration for Nonmetro Areas, 1970–2000." *Rural America*, Volume 17, Issue 3, Fall 2002, pp. 11–20.

Gale, Fred. "The Graying of the Farm Sector: The Legacy of Off-Farm Migration." *Rural America*, Volume 17, Issue 3, Fall 2002, pp. 28–31.

Reeder, Richard J. and Samuel Calhoun. "Federal Funding in Nonmetro Elderly Counties." *Rural America*, Volume 17, Issue 3, Fall 2002, pp. 20–27.

Rogers, Carolyn C. "Implications of Medicare Restructuring for Rural America." *Rural America*, Volume 17, Issue 2, Summer 2002, pp. 37–43.

Rogers, Carolyn C. "Rural Health Issues for the Older Population." *Rural America*, Volume 17, Issue 2, Summer 2002, pp. 30–36.

Rogers, Carolyn C. "The Older Population in 21st Century Rural America." *Rural America*, Volume 17, Issue 3, Fall 2002, pp. 2–10.

ERS also conducts research on policy issues relevant to the food choices, health, and nutrition of the elderly population. Current research identifies the dietary needs of older Americans, the changes in food consumption and expenditure that will arise from an aging population, food safety risks faced by the elderly, and ways in which USDA's food and nutrition assistance program can better serve older Americans.

PUBLICATIONS ON DIET, HEALTH, AND NUTRITION ISSUES

ERS released the following publications on diet, health, and nutrition issues faced by older Americans:

Blisard, Noel, Biing-Hwan Lin, John Cromartie, and Nicole Ballenger. "America's Changing Appetite: Food Consumption and Spending to 2020." *FoodReview*, Volume 25, Issue 1, Spring 2002, pp. 2–9.

Buzby, Jean C. "Older Adults at Risk of Complications from Microbial Foodborne Disease." *FoodReview*, Volume 25, Issue 2, Summer/Fall 2002, pp. 30–35.

Cromartie, John C. "Population Growth and Demographic Change, 1980–2020." *FoodReview*, Volume 25, Issue 1, Spring 2002, pp. 10–12.

Guthrie, Joanne and Biing-Hwan Lin. "Overview of the Diets of Lower and Higher Income Elderly and Their Food Assistance Options." *Journal of Nutrition Education and Behavior*, Volume 34, March-April 2002, pp. S31–S41.

Guthrie, Joanne F. and Biing-Hwan Lin. "Older Americans Need to Make Every Calorie Count." *FoodReview*, Volume 25, Issue 2, Summer/Fall 2002, pp. 8–13.

Harris, J. Michael and Noel Blisard: "Food Spending and the Elderly." *FoodReview*, Volume 25, Issue 2, Summer/Fall 2002, pp. 14–18.

Nord, Mark. "Food Security Rates are High for Elderly Households." *FoodReview*, Volume 25, Issue 2, Summer/Fall 2002, pp. 19–24.

Rogers, Carolyn C. "America's Older Population." *FoodReview*, Volume 25, Issue 2, Summer/Fall 2002, pp. 2–7.

Wilde, Parke and Elizabeth Dagata: "Food Stamp Participation by Eligible Older Americans Remains Low." *FoodReview*, Volume 25, Issue 2, Summer/Fall 2002, pp. 25–29.

FOOD AND NUTRITION SERVICE

USDA's Food and Nutrition Service (FNS) addresses the needs of older Americans and their families through a number of programs, including the Food Stamp Program, the Commodity Supplemental Food Program, the Food Distribution Program on Indian Reservations, the Child and Adult Care Food Program, The Emergency Food Assistance Program, the Nutrition Services Incentive Program, and the Senior Farmers' Market Nutrition Program. Each is summarized briefly below.

FOOD STAMP PROGRAM

The Food Stamp Program (FSP) provides monthly benefits to help low-income families and individuals purchase a more nutritious diet. In FY 2002, $18 billion in food stamps was provided to a monthly average of 19 million persons.

Households with elderly members accounted for approximately 19 percent of the total food stamp caseload. However, since these households were smaller, on average, and had relatively higher net income, they received only 7 percent of all benefits issued.

The FSP has been at the forefront of efforts to reduce hunger and food insecurity among the elderly. Key accomplishments are highlighted below.

Program Changes in the Farm Bill To Benefit the Elderly

During FY 2002, the Farm Bill (P.L. 107–171) reauthorized and made several changes to the FSP that will help elderly participants. The most direct benefit to the elderly came through the restoration of eligibility to disabled legal immigrants and all legal immigrants in the country for at least 5 years. A number of important changes, such as simplification of income deductions, will help all participants, including the elderly. Other provisions, such as $5

million grants for access and outreach and having applications on the Internet, will help to improve access for elderly people.

One-Stop Application Demonstrations for Supplemental Security Income (SSI) and FSP Participants

FNS continues to work closely with the Social Security Administration (SSA) to meet the legislative objectives of the Combined Application Project (CAP) for SSI households. The CAP demonstrations improve the delivery of food assistance to the elderly and disabled by streamlining the food stamp application process for recipients of SSI. The initial CAP project, the South Carolina Combined Application Project (SCCAP), was implemented in 1995 and still is in operation. Under the demonstration, one-person SSI households have their eligibility for food stamps and their benefit amounts determined by automatic utilization of data collected by SSA during the SSI interview. This information is transferred electronically to the State food stamp office through SSA's State Data Exchange system. If the individual is determined eligible for SSI, a food stamp case is opened automatically for that person. Individuals, therefore, do not need to file a separate food stamp application or have any contact with the food stamp office. A recent evaluation of SCCAP indicates that the demonstration has been successful in increasing food stamp participation among the elderly.

In 2001, FNS and SSA expanded the CAP demonstration to two additional States, Mississippi and Washington. A year later (September 2002), Texas implemented a variation of CAP-a Special Nutrition Assistance Project focusing on outreach. SSI applications are not automatically certified for food stamps based on their SSI data. Rather, the State agency uses SSA data to identify individuals who are receiving SSI but who are not participating in food stamps and provides them with streamlined food stamp application procedures (e.g., shortened application and no face-to-face interview).

In December 2002, FNS and SSA began working on further expanding the number of State agencies operating CAP demonstrations. On December 31, 2002, plans were announced to expand the standard CAP projects to three additional States over the next year. In addition to these three, as many States as possible will be allowed to operate the modified version used in Texas.

Pilots of Alternative Approaches To Improve Service to Elderly Participants

Approximately $2 million in grants was awarded in 2001 to six State food stamp agencies (Florida, Maine, Michigan, Arizona, Connecticut, and North Carolina) to conduct elderly nutrition pilot projects. The purpose of these pilots is to test three different approaches to eliminate barriers to participation in the FSP by eligible persons age 60 years and older.

The three approaches are: (1) simplification of eligibility and benefit determination rules, (2) one-on-one assistance with the application process, and (3) an optional commodity alternative that provides a monthly food package instead of food stamps. The pilots began operating in FY 2002 and will run until the end of FY 2004.

Mathematica Policy Research is evaluating the pilots independently under a contract with the Economic Research Service. Early

findings suggest that participation increased in the two pilots that began in early FY 2002. In the Florida counties testing the simplified rules approach, elderly participation grew by over 5 percent, adjusting for trends in comparison counties. In the Maine site testing the application assistance approach, elderly participation increased 29 percent over the comparison county.

Enhanced Efforts To Reach Elderly People as Part of Broader Access and Outreach Initiatives

FNS has a wide range of efforts underway, including:

- Development of a guide, "Help for the Elderly and Disabled: A Primer for Enhancing the Nutrition Safety Net for the Elderly and Disabled," which was distributed to appropriate agencies and organizations. The purpose of this guide is to (1) assist State policymakers and others in understanding the special rules embedded in the Food Stamp Act of 1977 (as amended) and the FSP regulations for elderly and disabled individuals, (2) assist States and others in identifying participation barriers that elderly and disabled people face in seeking nutrition assistance through the FSP, and (3) assist States and others in identifying possible outreach activities available to increase participation among elderly and disabled people.
- An educational campaign with the theme of "Food Stamps Make America Stronger" to increase awareness of the FSP among target audiences, including the elderly. Bilingual posters and fliers, some featuring elderly persons, are available free via an easy-to-use online ordering form. CD–ROMs also are available for local organizations that wish to customize the materials for their community.
- A bilingual toll-free information number (1–800–221–5689), which is available 24 hours a day. Callers are sent a packet of information about the program and are connected to State toll-free numbers, if available, for more detailed information.
- Award of $3 million in research grants in January 2001 and $5 million in September 2002 to improve FSP access through partnerships and new technology. The purpose of the grants is to explore various strategies to reach potentially eligible households and to educate people eligible for food stamps who are not currently participating in the FSP about the benefits of the program and how to apply for these benefits. One of the target populations for these grants is the elderly.

COMMODITY SUPPLEMENTAL FOOD PROGRAM

The Commodity Supplemental Food Program (CSFP) provides supplemental foods, in the form of commodities, and nutrition education to infants and children up to age 6; pregnant, postpartum and breastfeeding women; and elderly people (at least 60 years of age) who have low incomes and reside in approved project areas.

Service to the elderly began in 1982 with pilot projects. In 1985, legislation allowed the participation of older Americans outside the pilot sites if available resources exceeded those needed to serve women, infants, and children. In FY 2002, nearly $71 million was spent on the elderly component.

About 72 percent of total program spending provides supplemental food to more than 350,000 elderly participants a month. Older Americans are served by 23 of the 23 eligible State agencies.

FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS

The Food Distribution Program on Indian Reservations (FDPIR) provides commodity packages to eligible households, including households with elderly persons, living on or near Indian reservations. Under this program, commodity assistance is provided in lieu of food stamps.

Approximately $26 million of total costs went to households with at least one elderly person in FY 2002. (This figure was estimated using a 1990 study that found that approximately 39 percent of FDPIR households had at least one elderly individual.)

The program serves approximately 43,000 households with elderly participants per month.

CHILD AND ADULT CARE FOOD PROGRAM

The Child and Adult Care Food Program (CACFP) provides Federal funds to initiate, maintain, and expand nonprofit food service for children, the elderly, or impaired adults in nonresidential institutions that provide child or adult care. The program enables child and adult care institutions to integrate a nutritious food service with organized care services.

The adult day care component permits adult day care centers to receive reimbursement for meals and supplements served to functionally impaired adults and to persons 60 years or older. An adult day care center is any public or private nonprofit organization or any proprietary Title XIX or Title XX center licensed or approved by Federal, State, or local authorities to provide nonresidential adult day care services to functionally impaired adults and persons 60 years or older. In FY 2002, $57 million was spent on the adult day care component.

Under the adult day care component of CACFP, nearly 45 million meals and supplements were served to more than 82,000 participants per day in FY 2002.

In 1993, the National Study of the Adult Component of CACFP was completed. Some of the major findings of the study include the following:

- Overall, about 31 percent of all adult day care centers participate in CACFP; about 43 percent of centers eligible for the program participate.
- CACFP adult day care clients have low incomes; 84 percent have incomes of less than 130 percent of the Federal poverty guidelines.
- Many participants consume more than one reimbursable meal daily; CACFP meals contribute just under 50 percent of a typical participant's total daily intake of most nutrients.

THE EMERGENCY FOOD ASSISTANCE PROGRAM

The Emergency Food Assistance Program (TEFAP) provides nutrition assistance in the form of commodities to emergency feeding organizations, including food pantries, which distribute food to low-

income households for household consumption and to soup kitchens, which provide meals to low-income households.

In FY 2002, Congress appropriated $150 million for TEFAP–$100 million for commodities and $50 million for administrative support for State and local agencies.

A follow-up study on clients of TEFAP providers estimated that in 2001, approximately 25 percent of the 4.3 million households receiving food from food pantries contained an elderly member. Of the 1.1 million individuals served by soup kitchens, 15 percent were elderly.

NUTRITION SERVICES INCENTIVE PROGRAM

The Nutrition Services Incentive Program (NSIP) rewards effective performance by States and Tribal organizations in the efficient delivery of nutritious meals to older individuals through the use of cash or commodities. As amended by the Older Americans Act of 2000, the NSIP is the new name for USDA's cash or commodity program, formerly known as the Nutrition Program for the Elderly.

The NSIP is based on a new formula grant rather than the old reimbursement model. Under the 2000 amendments, the NSIP cash or cash and commodity allocation to a State agency on aging, or to a Tribal organization, is based on the number of meals actually served in the previous year in relation to the total number of meals actually served by all States or Tribes in the previous year.

The Consolidation Appropriations Act (2003) amended the Older Americans Act of 1965 to transfer program appropriations for NSIP, as well as the responsibility for the allocation of resources in the program, from USDA to the U.S. Department of Health and Human Services. However, the legislation still allows participating NSIP local agencies to choose to receive all or part of their allocations in USDA commodities. USDA remains responsible for the ordering, purchase, and delivery of commodities to these agencies.

In FY 2001, USDA provided reimbursement for an average of 21 million meals a month at a cost of almost $150 million.

SENIOR FARMERS' MARKET NUTRITION PROGRAM

The Senior Farmers' Market Nutrition Program (SFMNP) is a new program in which grants are provided to States, United States territories, and Federally recognized Indian tribal governments to provide low-income seniors with coupons that can be exchanged for eligible foods (fresh, nutritious, unprepared, locally grown fruits, vegetables, and herbs) at farmers' markets and roadside stands and through community-supported agriculture programs. The SFMNP also is intended to increase the consumption of agricultural commodities by expanding, developing, or aiding in the development and expansion of domestic farmers' markets, roadside stands, and community-supported agriculture programs.

State agencies were awarded grants through the competitive grant process when the SFMNP was begun as a pilot program in FY 2001 and in FY 2002. The SFMNP was given permanent status under Public Law 107–171, the Farm Security and Rural Investment Act of 2002, and the USDA Food and Nutrition Service is now developing regulations to establish the SFMNP as one of the agency's permanent nutrition assistance programs. This legislation also earmarks an annual $15 million out of Commodity Credit Cor-

poration (CCC) funds for FY 2003–2007 and gives the Department of Agriculture authority to develop program regulations.

In FY 2002, just over 500,000 seniors received and used SFMNP coupons to purchase eligible foods at authorized farmers' markets and roadside stands and through community-supported agriculture programs. In FY 2002, eligible foods were available from more than 10,000 farmers at 1,500 farmers' markets and 1,000 roadside stands as well as through more than 200 community-supported agriculture programs.

Nutrition education, also an important component of the SFMNP, is provided in a variety of forms to all program recipients.

CENTER FOR NUTRITION POLICY AND PROMOTION

During calendar years 2001 and 2002, Center for Nutrition Policy and Promotion (CNPP) staff participated in a number of research activities related to the elderly. In particular, this research focused on diet quality, hydration status, physical activity, and health-related issues of aging.

The following is a list of publications (P) and presentations (PR) prepared by CNPP staff to report this research:

2001

Gerrior, S.A. "Fat Intake and Anthropometric Measures of Physically Active Older Women." American College of Sports Medicine Annual Meeting, Baltimore, MD. May 2001. (PR)

Gerrior, S.A. "Body Composition and Nutrient Intake of Older Male Exercisers." SCAN (Sports, Cardiovascular and Wellness Nutritionists) Annual Conference, Washington, DC. July 2001. (PR)

2002

Basiotis, P.P., Carlson, A., Gerrior, S.A. Juan, W.Y., and Lino, M. (Authors in alphabetical order.) (2002). "The Healthy Eating Index: 1999–2000." U.S. Department of Agriculture, Center for Nutrition Policy and Promotion, CNPP–12. December 2002. (Section on people over 50 years of age.) (P)

Gaston, N., and Munroe, S.G. "Directory of Nutrition and Aging Web Sites." Journal of Nutrition Education and Behavior 34: Supplement 1; S59–S64 March/April 2002. (P)

Gerrior, S.A. "The Nutrient and Anthropometric Status of Physically Active and Inactive Older Adults." Journal of Nutrition Education and Behavior 34: Supplement 1; S5–13 March/April 2002. (P)

Gerrior, S. "Dietary Intake and Physical Activity in Women: Changes with Age." Annual Meeting of the Society for Nutrition Education, St. Paul, MN. July 2002. (PR)

Hiza, H.A.B, and Juan, W. "Categories of Reported Intakes and Prevalence of Chronic Disease Risk Factors in Adult Females." Meeting of the Society for Nutrition Education, St. Paul, MN. July 2002. (PR)

Juan, W., and Hiza, H.A.B. "Vitamin Supplementation and Health Indicators Among Elderly Women." American Public Health Association. Philadelphia, PA. November 2002. (PR)

Hiza, H.A.B, and Juan, W. "Categories of Reported Intakes and Prevalence of Chronic Disease Risk Factors in Adult Males." American Public Health Association. Philadelphia, PA. November 2002. (PR)

Juan, W., and Basiotis, P.P. "More Than One in Three Older Americans May Not Drink Enough Water." Nutrition Insights, Insight #27. September 2002. (P)

ITEM 2_DEPARTMENT OF COMMERCE

UPDATES TO THE *DEVELOPMENTS IN AGING* REPORT FOR 2001 AND 2002

This report provides short descriptions and listings of products that contain demographic and socioeconomic information on the older population, those aged 65 and older, here and abroad. All of the items included in this report were released by the U.S. Census Bureau during calendar years 2001 and 2002.

The items listed are available to the public in a variety of formats, including print, electronic data bases, microdata files, CD-ROMs, and DVDs. Many of these products can be found on the Internet at the Census Bureau's Web site at **www.census.gov.**

The report is organized by the five major topics shown below.

1. Population and Housing Reports

Three of the Census Bureau's major report series (*Current Population Reports, Current Housing Reports,* and *International Population Reports*) are important sources of demographic information on a wide variety of topics. Reports include information on the size of the United States' older population and characteristics, such as income, health insurance coverage, need for assistance with activities of daily living, and housing situations. Additionally, data on the older population around the world also are found in this series of reports.

Current Population Reports are derived mostly from the Current Population Survey and the Survey of Income and Program Participation. *Current Housing Reports* are based on the American Housing Survey, a biennial national survey of approximately 55,000 housing units. The *International Population Report* series includes demographic and socioeconomic data reported by various national statistical offices, such as the National Institute on Aging, agencies of the United Nations, and the Organization for Economic Cooperation and Development.

The Census Bureau's population projection program and *Special Studies* series also contain information about the future size of the older population and other information.

2. Decennial Products

Summary files, CD-ROMs, DVDs, and printed reports are produced after each decennial census and include information on the number and characteristics of the older population.

3. Database on Aging/National Institute on Aging Products

The database summarized studies and other ongoing international aging products. Reports are based on compilations of data obtained from individual country statistical offices, various international organizations, and estimates and projections prepared at the Census Bureau. This work is funded by the National Institute on Aging.

4. Federal Interagency Forum on Aging-Related Statistics Summary

The Forum, for which the Census Bureau is one of the lead agencies, encourages cooperation, analysis, and dissemination of data pertaining to the older population.

5. Other Products

This category includes other data products that contain demographic and socioeconomic information on the older population.

I. POPULATION, HOUSING, AND INTERNATIONAL REPORTS

POPULATION

Series P-20 (Population Characteristics)

Reports in this series contain data from the Current Population Survey. Topics include geographical residence and mobility; fertility; school enrollment; educational attainment; marital status and living arrangements; households and families; the Black and Asian and Pacific Islander and the Hispanic or Latino populations; voter registration and participation; and various other topics for the general population and the older population. These reports can be found on the Census Bureau's Web site at: http://www.census.gov/prod/www/abs/popula.html.

Series P-23 (Special Studies)

This series includes occasional reports on family life, women, voter turnout, computer use, and other topics. These reports can be found on the Census Bureau's Web site at: http://www.census.gov/prod/www/abs/popula.html.

Population Estimates

We publish July 1 population estimates for years after the last decennial census (2000), based on births, deaths, and domestic and international migration. These estimates are used in federal funding allocations, as denominators for vital rates and per capita time series, as survey controls, and in monitoring recent demographic changes. With each new issue of July 1 estimates, we revise estimates for years back to the last census. Previously published estimates are superseded and archived.

National Population Estimates—http://eire.census.gov/popest/data/national.php

The U.S. Census Bureau's Population Estimates Program develops and releases monthly national population estimates by demographic characteristics. These estimates cover four different populations: resident population, resident population plus Armed Forces overseas, civilian population, and civilian noninstitutional population.

National population estimates released in the spring of each year show estimates by age, sex, race, and Hispanic origin for the preceding July 1.

State Population Estimates (Includes: United States, Regions, Divisions, and States)—http://eire.census.gov/popest/data/states/stasro.php

The Census Bureau's Population Estimates Program publishes state population estimates as of July 1 of each year for total population with details on age, sex, race, and Hispanic origin. The releases give numbers for single years of age, different age groupings, and median age for each state and the District of Columbia.

County Population Estimates—http://eire.census.gov/popest/data/counties/coasro.php

The Census Bureau's Population Estimates Program publishes county total population estimates each year by age, sex, race, and Hispanic origin. The reference date for county estimates is July 1.

Housing Unit Estimates—http://eire.census.gov/popest/data/household.php

The Census Bureau's Population Estimates Program publishes estimates of housing units for the United States, states, and counties. The reference date for these estimates is July 1.

Population Projections

National Population Projections—
http://www.census.gov/population/www/projections/natproj.html

The Population Projections Program projects the United States resident population by age, sex, race, Hispanic origin, and nativity. The projections are based on assumptions about future births, deaths, and international migration. Alternative series are produced and updated periodically.

Series P-60 (Consumer Income)

Information concerning families, individuals, and households at various income levels is presented in this group of reports. Data also are presented on noncash benefits and the relationship of income to age, sex, race, family size, education, occupation, work experience, and

other characteristics. These reports can be found on the Census Bureau's Web site at http://www.census.gov/prod/www/abs/popula.html#income.

Title	Report Number
Money Income in the United States: 2000	213
Poverty in the United States: 2000	214
Health Insurance Coverage: 2000	215
Experimental Poverty Measures: 1999	216
Money Income in the United States: 2001	218
Poverty in the United States: 2001	219
Health Insurance Coverage: 2001	220

Series P-70 (Household Economic Studies)

These data are from the Survey of Income and Program Participation (SIPP), a national survey conducted by the Census Bureau. Its principal purpose is to provide estimates of money and in-kind income and participation in government programs. Recurrent questions focus on employment, types of income, and noncash benefits. These reports include data on the older population and can be found on the Census Bureau's Web site at http://www.census.gov/prod/www/abs/popula.html#income.

Title	Report Number
Household Net Worth and Asset Ownership	71
What's It Worth? Field of Training and Economic Status: 1996	72
Americans with Disabilities: 1997	73
Did You Know? Homes Account for 44 Percent of All Wealth: Findings from SIPP	75
Reasons People Do Not Work	76
Dynamics of Economic Well-Being: Program Participation, 1993 to 1995—Who Gets Assistance?	77
Home-Based Workers in the United States: 1997	78
Number, Timing, and Duration of Marriages and Divorces: 1996	80
Employment-Based Health Insurance: 1997	81
Financing the Future: Postsecondary Students, Costs, and Financial Aid: 1996-1997	83
WHO'S HELPING OUT? Financial Support Networks Among American Households: 1997	84
Net Worth and Asset Ownership of Households: 1998 and 2000	88

Series PPL (Population Paper Listings)

These reports contain estimates and projections of the population by age, sex, origin, and other topics, some of which address issues related to aging. These reports can be found on the Census Bureau's Web site at http://www.census.gov/population/www/ppl-list.html.

Technical Working Paper Series

This series contains technical papers written by staff of the Population Division of the Census Bureau. Evaluations of population projections, estimates, and census results are included along with other studies of immigration, race and ethnicity, and fertility.

Series SB/CENBR (*Statistical Briefs*)

These succinct reports are issued occasionally and provide timely data on specific issues. Presented in narrative style with charts, the reports summarize data from economic and demographic censuses and surveys. In December 1996, the *Statistical Brief* series format was revised and became known as *Census Briefs*. These reports can be found on the Census Bureau's Web site at http://www.census.gov/prod/www/abs/briefs.html

Title	Report Number
The Older Foreign-Born Population in the United States: 2000	02-2

International Population Reports

The International Population Reports include demographic and socioeconomic data reported by various national statistical offices, such as the National Institute on Aging, agencies of the United Nations, and the Organization for Economic Cooperation and Development. These reports can be found on the Census Bureau's Web site at http://www.census.gov/ipc/www/publist.html

Title	Report Number
An Aging World: 2001	P95/01-1

HOUSING

Series H-150 (Housing Characteristics for the United States)

These data are from the American Housing Survey (AHS). The AHS presents data on the Nations's housing, including apartments; single-family homes; mobile homes; vacant housing units; age, sex, and race of householders; housing and neighborhood quality; housing costs; equipment and fuels; and size of housing units. Reports also present data on homeowners' repairs and mortgages, rent control, rent subsidies, previous units of recent movers, and reasons for moving. These reports can be found on the Census Bureau's Web site at http://www.census.gov/hhes/www/ahs.html

Title	Report Number
American Housing Survey for the United States: 2001	150/01
American Housing Survey for the United States: 2001 (Wallchart)	H150/01Wall
Our Homes, Our Neighbors.	AHB/01-2

Series H-170 (Housing Characteristics for Selected Metropolitan Areas)

A separate report that presents data for individual metropolitan areas for the same characteristics are shown in Series H-150. Eleven to 13 metropolitan areas are interviewed each year. They are surveyed on a rotating basis, with a total of 48 metropolitan areas being surveyed within a 6-year period.

Housing Vacancy Survey

Each quarter a press release presents data on homeownership by age of householder. Press releases can be found on the Census Bureau's Web site at http://www.census.gov/hhes/www/ahs.html.

II. DECENNIAL PRODUCTS

Census 2000

Data on the older population from Census 2000 are contained in a series of products that include summary files, printed reports, geographic comparison tables, special briefs and reports, and microdata. Most of the information can be accessed through the Internet and on CD-ROM or DVD. These files and data products are described below.

Census 2000 Summary Files

Summary File 1 (SF 1) contains 286 detailed tables focusing on age, sex, households, families, and housing units. These tables provide in-depth figures by race and Hispanic origin; some tables are repeated for each of nine race/Latino groups. Counts also are provided for over 40 American Indian and Alaska Native tribes and for groups within race categories. The race categories include 18 Asian groups and 12 Native Hawaiian and Other Pacific Islander groups. Counts of persons of Hispanic origin by country of origin (28 groups) are also shown. SF1 can be found on the Census Bureau's Web site at: http://www.census.gov/Press-Release/www/2001/sumfile1.html.

The 16 tables in SF 1 that present data on the older population are listed below:

Number	Table Title
P12	Sex by Age
P13	Median Age by Sex
P20	Households by Age of Householder by Household Type (Including Living Alone) by Presence of Own Children
P21	Household Type by Age of Householder
P22	Households by Presence of People 60 Years and Over, Household Size, and Household Type

P23	Households by Presence of People 65 Years and Over, Household Size, and Household Type
P24	Households by Presence of People 75 Years and Over, Household Size, and Household Type
P30	Relationship by Household Type (Including Living Alone) for the Population 65 Years and Over
P37	Group Quarters Population by Group Quarters Type
P38	Group Quarters Population by Sex by Age by Group Quarters Type
PCT12	Sex by Age
PCT13	Sex by Age
PCT16	Group Quarters Population by Group Quarters Type
PCT17	Group Quarters Population by Sex by Age by Group Quarters Type
H16	Tenure by Age Householder
H17	Tenure by Household Type (Including Living Alone) by Age of Householder

Summary File 2 (SF 2)—Similar to SF 1, SF 2 contains 100-percent population and housing characteristics, but the tables are iterated for a selected list of detailed race and Hispanic or Latino origin groups, as well as American Indian and Alaska Native tribes. The lowest level of geography is the census tract, and there is a population-size threshold before information is shown for a particular group. SF 2 can be found on the Census Bureau's Web site at http://www.census.gov/Press-Release/www/2001/sumfile2.html.

The 11 tables in SF 2 that present data on the older population are listed below:

Number	Table Title
PCT3	Sex by Age
PCT4	Median Age by Sex
PCT5	Sex by Age
PCT11	Households by Age of Householder by Household Type (Including Living Alone) by Presence of Own Children
PCT12	Household Type by Age of Householder
PCT13	Households by Presence of People 60 Years and Over, Household Size, and Household Type
PCT14	Households by Presence of People 65 Years and Over, Household Size, and Household Type
PCT15	Households by Presence of People 75 Years and Over, Household Size, and Household Type
PCT21	Relationship by Household Type (Including Living Alone) for the Population 65 Years and Over
HCT8	Tenure by Age of Householder
HCT9	Tenure by Household Type (Including Living Alone) by Age of Householder

Summary File 3 (SF 3) contains tables with social, economic, and housing characteristics compiled from a sample of approximately 19 million housing units (about 1-in-6 households) that received the Census 2000 long-form questionnaire. Many tables are given for nine major race and Hispanic or Latino groups. Ancestry group population counts are included. Data are provided down to the block group for many tabulations, but only down to the census tract for others. SF 3 also includes data by ZIP Code Tabulation Area and Congressional District. SF 3 can be found on the Census Bureau's Web site at http://www.census.gov/Press-Release/www/2002/sumfile3.html.

The 62 tables in SF 3 that present data on the older population are listed below:

Number	Table Title
P8	Sex by Age
P11	Household Type (Including Living Alone) by Relationship for the Population 65 Years and Over
P12	Households by Age of Householder by Household Type (Including Living Alone) by Presence of Own Children Under 18 Years
P13	Households Type by Age of Householder
P19	Age by Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over
P39	Sex by Age by Armed Forces Status by Veteran Status for the Population 18 Years and Over
P41	Age by Types of Disability for the Civilian Noninstitutionalized Population 5 Years and Over with Disabilities
P42	Sex by Age by Disability Status by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over
P55	Age of Householder by Household Income in 1999
P56	Median Household Income in 1999 (Dollars) by Age of Householder
P57	Aggregate Household Income in 1999 (Dollars) by Age of Householder
P87	Poverty Status in 1999 by Age
P89	Poverty Status in 1999 by Age by Household Type
P92	Poverty Status in 1999 of Households by Households Type by Age of Householder
P145A	Sex by Age (White Alone)
P146A	Households by Age of Householder by Household Type (Including Living Alone) by Presence of Own Children Under 18 Years (White Alone Householder)
P159A	Poverty Status in 1999 by Age (White Alone)
PCT2	Nonfamily Households by Sex of Householder by Living Alone by Age of Householder
PCT3	Family Type by Age of Householder
PCT7	Sex by Marital Status by Age for the Population 15 Years and Over

PCT8	Grandparents Living with Own Grandchildren Under 18 Years by Responsibility for Own Grandchildren by Length of Time Responsible for Grandchildren for the Population 30 Years and Over in Households
PCT9	Household Relationship by Grandparents Living with Own Grandchildren Under 18 Years by Responsibility for Own Grandchildren for the Population 30 Years and Over in Households
PCT13	Age by Language Spoken at Home for the Population 5 Years and Over in Linguistically Isolated Households
PCT14	Language Density by Linguistic Isolation by Age for the Population 5 Years and Over in Households
PCT25	Sex by Age by Educational Attainment for the Population 18 Years and Over
PCT26	Sex by Age by Types of Disability for the Civilian Noninstitutionalized Population 5 Years and Over
PCT27	Sex by Age by Sensory Disability by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over
PCT28	Sex by Age by Physical Disability by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over
PCT29	Sex by Age by Mental Disability by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over
PCT30	Sex by Age by Self-Care Disability by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over
PCT31	Sex by Age Go-Outside-Home Disability by Employment Status for the Civilian Noninstitutionalized Population 16 and Over
PCT34	Sex by Age by Disability Status by Poverty Status for the Civilian Noninstitutionalized Population 5 Years and Over
PCT35	Sex by Age by Employment Status for the Population 16 Years and Over
PCT37	Aggregate Family Income in 1999 (Dollars) by Family Type by Age of Householder
PCT42	Median Nonfamily Household Income in 1999 (Dollars) by Sex of Householder by Living Alone by Age of Householder
PCT43	Aggregate Nonfamily Household Income in 1999 (Dollars) by Sex of Householder by Living Alone by Age of Householder
PCT49	Poverty Status in 1999 by Sex by Age
PCT50	Age by Ratio of Income in 1999 to Poverty Level
PCT53	Poverty Status in 1999 of Unrelated Individuals 15 Years and Over by Sex by Age
PCT55	Poverty Status in 1999 of Unrelated Individuals by Sex by Age by Householder Status (Including Living Alone)
PCT62A	Age by Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over (White Alone)
PCT66A	Sex by Age by Armed Forces Status by Veteran Status for the Population 18 Years and Over (White Alone)
PCT67A	Age by Types of Disability for the Civilian Noninstitutionalized Population 5 Years and Over with Disabilities (White Alone)

PCT68A	Sex by Age by Disability Status by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over (White Alone)
PCT72A	Age of Householder by Household Income in 1999 (White Alone Householder)
PCT 75A	Poverty Status in 1999 by Sex by Age (White Alone)
H14	Tenure by Age of Householder
H19	Tenure by Household Type (Including Living Alone) by Age of Householder
H21	Tenure by Age of Householder by Occupant per Room
H43	Tenure by Telephone Service Available by Age of Householder
H45	Tenure by Vehicles Available by Age of Householder
H53	Age of Householder by Meals Included in Rent
H71	Age of Householder by Gross Rent as a Percentage of Household Income in 1999
H78	Aggregate Value (Dollars) for Specified Owner-Occupied Housing Units by Age of Householder
H96	Age of Householder by Selected Monthly Owner Costs as a Percentage of Household Income in 1999
HCT2	Tenure by Household Size by Age of Householder
HCT4	Tenure by Age of Householder by Units in Structure
HCT5	Tenure by Age of Householder by Year Structure Built
HCT7	Tenure by Age of Householder by Year Householder Moved Into Unit
HCT14	Aggregate Household Income in 1999 (Dollars) by Tenure by Age of Householder by Units in Structure
HCT15	Aggregate Household Income in 1999 (Dollars) by Tenure by Age of Householder by Year Structure Built
HCT16	Aggregate Household Income in 1999 (Dollars) by Tenure by Age of Householder by Year Householder Moved Into Unit
HCT24	Tenure by Poverty Status in 1999 by Age of Householder

Geographic Comparison Tables

The Census 2000 Geographic Comparison Tables enable users to compare key data items across geographic areas. The five geographic comparison tables that present data on the older population are listed below:

Number	Table Title
GCT-H6	Occupied Housing Characteristics: 2000
GCT-P5	Age and Sex: 2000
GCT-P7	Households and Families: 2000
GCT-P15	Selected Age Groups: 2000
GCT-P14	Income and Poverty in 1999: 2000

Quick Tables

The Census 2000 Quick Tables allow users to choose tables shells, then specify the geographic area and the universe or population subgroup. The 19 quick tables that present data on the older population are listed below:

Number	Table Title
DP-1	Profile of General Demographic Characteristics: 2000
QT-H1	General Housing Characteristics: 2000
QT-H2	Tenure, Household Size, and Age of Householder: 2000
QT-H3	Household Population and Household Type by Tenure: 2000
QT-P1	Age Groups and Sex: 2000
QT-P2	Single Years of Age Under 30 Years and Sex: 2000
QT-P11	Household Relationship and Group Quarters Population: 2000
QT-P12	Group Quarters Population by Sex, Age, and Type of Group Quarters: 2000
DP-2	Profile of Selected Social Characteristics: 2000
DP-3	Profile of Selected Economic Characteristics: 2000
QT-H10	Units in Structure, Householder 65 Years and Over, and Householder Below Poverty Level: 2000
QT-P17	Ability to Speak English: 2000
QT-P18	Marital Status by Sex, Unmarried Partner Household, and Grandparents as Caregivers: 2000
QT-P20	Educational Attainment by Sex: 2000
QT-P21	Disability Status by Sex: 2000
QT-P24	Employment Status by Sex: 2000
QT-P33	Income in 1999 by Selected Households, Family, and Individual Characteristics: 2000
QT-P34	Poverty Status in 1999 of Individuals: 2000
QT-P35	Poverty Status in 1999 of Families and Nonfamily Householders: 2000

Printed Reports

The PHC-1, *Summary Population and Housing Characteristics,* report series provides data based on the 100-percent questions. The subjects are age, Hispanic or Latino origin, household relationship, race, sex, tenure (owner- or renter-occupied), and vacancy characteristics. Land area measurements and population density also are provided. This series is similar to the 1990 census CPH-1 series. The PHC-1 can be found on the Census Bureau's Web site at http://www.census.gov/census2000/pubs/phc-1.html.

The 8 PHC-1 tables that present data on the older population are listed below:

Number	Table Title
Table 1	Age and Sex: 2000
Table 2	Age and Sex: 2000
Table 7	Households and Families: 2000
Table 8	Households and Families: 2000
Table 17	Age and Sex for the American Indian and Alaska Native Population (One Race): 2000
Table 20	Households and Families with American Indian and Alaska Native Householder (One Race): 2000
Table 25	Age and Sex for the Native Hawaiian and Other Pacific Islander Population (One Race): 2000
Table 28	Households and Families with Native Hawaiian and Other Pacific Islander Householder (One Race): 2000

The PHC-2, *Summary Social, Economic, and Housing Characteristics,* report series provides data from both the 100-percent and the sample questions. Subjects include place of birth; residence in 1995; language; educational attainment and school enrollment; veterans status; disability status; employment status; journey to work; work status, earnings, income, and poverty status in1999; physical housing characteristics; units in structure; fuel and equipment characteristics; owner and renter household characteristics, such as year owner moved into unit; home value; contract and gross rent; and mortgage and rental cost characteristics. This series is similar to the 1990 census CPH-5 series. The PHC-2 can be found on the Census Bureau Web site at http://www.census.gov/census2000/pubs/phc-2.html.

The 12 tables in PHC-2 that present data on the older population are listed below:

Number	Table Title
Table 3	Education and Veteran Status: 2000
Table 4	Education and Veteran Status: 2000
Table 5	Disability Status: 2000
Table 6	Disability Status: 2000
Table 15	Poverty Status in 1999: 2000
Table 16	Poverty Status in 1999: 2000
Table 34	Education and Veterans Status for the American Indian and Alaska Native Population (One Race): 2000
Table 35	Disability Status for the American Indian and Alaska Native Population (One Race): 2000
Table 40	Poverty Status in 1999 for the American Indian and Alaska Native Population (One Race): 2000
Table 50	Education and Veterans Status for the Native Hawaiian and Other Pacific Islander Population (One Race): 2000

Table 51	Disability Status for the Native Hawaiian and Other Pacific Islander Population (One Race): 2000
Table 56	Poverty Status in 1999 for the Native Hawaiian and Other Pacific Islander Population (One Race): 2000

Other Census 2000 Products

Demographic Profiles—A profile includes four tables that provide various demographic, social, economic, and housing characteristics. It includes 100-percent and sample data from Census 2000. The lowest level of geography is the census tract. http://www.census.gov/Press-Release/www/2002/demoprofiles.html

Congressional Districts Demographic Profile—Same as profile described above, except for Congressional Districts. The lowest level of geography is Congressional Districts of the 106th Congress.

Guide to Data on the Older Population in Census 2000 Summary Files 1-3— http://www.census.gov/population/www/socdemo/age/c2kguide.pdf

Microdata

Microdata allow users to prepare their own customized tabulation and cross-tabulations of most population and housing subjects. Two Public Use Microdata Sample (PUMS) files are available—a 1-percent file and a 5-percent file. PUMS are extracts of raw data from samples of long-form census records that are screened to protect confidentiality. One-percent files include data for the Nation and states, as well as substate areas where appropriate. Five-percent sample files have data for state and substate areas. On the 1-percent file, the lowest level of geography is Super Public Use Microdata Areas (Super-PUMAs) of 400,000 or more population. On the 5-percent file, the lowest level of geography is PUMAs of 100,000 or more population. PUMS files can be found on the Census Bureau's Web site at http://www.census.gov/main/www/cen2000.html.

Census 2000 *American FactFinder*

Census 2000 is the first census for which the Internet site is the primary means of disseminating the data. The *American FactFinder* (AFF) is the Census Bureau's primary online data retrieval tool and allows users to format tables, maps, and data sets for downloading, printing, viewing, and manipulating. The AFF also includes data from the 1990 census, the American Community Survey, Census 2000 Supplementary Survey, and the 1997 Economic Census. The AFF can be found on the Census Bureau's Web site at http://factfinder.census.gov/servlet/BasicFactsServlet.

The Census Bureau has created a "Census 2000 Gateway" page to pull together background information, questionnaires, links to the data sets, PDF files, tutorials, and other user aids. The page is http://www.census.gov/main/www/cen2000.html.

Census 2000 Briefs, Series C2KBR

The C2KBR series provides analysis of Census 2000 population and housing topics. The briefs focus on the most important aspects of each question on the census and explore the geographic distribution of the subject matter. The C2KBR series is designed to introduce the public to Census 2000 population and housing data. These reports can be found on the Census Bureau's Web site at http://www.census.gov/population/www/cen2000/briefs.html.

Listed below are Census 2000 Briefs and Special Reports that present data on the older population:

Title	Report Number
Households and Families: 2000	01-8
Gender: 2000	01-9
The 65 and Over Population: 2000	01-10
The United States in International Context: 2000	01-11
Age: 2000	01-12
Housing Characteristics: 2000	01-13

Population and Housing Tables (PHC-T Series)

The Census 2000 PHC-T tables cover a wide variety of topics, such as race, Hispanic or Latino origin, group quarters, and ancestry. These tables summarize data available through the Census Bureau's AFF database or present the results of other tabulations. A specific table(s) also may be released as an associated product of a Census 2000 Brief or a Census 2000 Special Report, providing more detail or cross-classification than provided in the published report. The number of tables in this series will grow as additional data from Census 2000 become available. These tables can be found on the Census Bureau's Web site at http://www.census.gov/population/www/cen2000/tablist.html.

Listed below are PHC-T tables that present data on the older population:

Table Number	Title
PHC-T-7	Group Quarters Population by Race and Hispanic Origin: 2000
PHC-T-8	Race and Hispanic or Latino Origin by Age and Sex for the United States: 2000
PHC-T-9	Population by Age, Sex, Race, and Hispanic or Latino Origin for the United States: 2000
PHC-T-13	Population and Ranking Tables of the Older Population for the United States, States, Puerto Rico, Places of 100,000 or More Population, and Counties: 2000

PHC-T-15 General Demographic Characteristics for the United States: 2000
PHC-T-23 Migration by Sex and Age for the Population 5 Years and Over for the United States, Regions, States, and Puerto Rico: 2000

Census 2000 Special Reports, Series CENSR

The CENSR series provides in-depth analyses of Census 2000 population and housing topics, particularly in the areas of geographic distribution, race and ethnicity, immigration, and other areas of demographic research. These reports can be found on the Census Bureau's Web site at http://www.census.gov/population/www/cen2000/briefs.html#sr.

Title	Report Number
Racial and Ethnic Residential Segregation in the United States: 1980-2000	0-03
Demographic Trends in the 20th Century	0-04
International Migration of the Older Population: 1995 to 2000	0-10

Decennial Supplementary Surveys

The American Community Survey (ACS) is a critical element in reengineering the 2010 census. The goals of the ACS are to provide federal, state, and local governments an information base for the administration and evaluation of government programs; improve the 2010 census; and provide data users with timely demographic, housing, social, and economic data updated every year for states, communities, and population groups. Information about the ACS can be found on the Census Bureau's Web site at http://www.census.gov/acs/www/.

Data Profiles

Data profiles contain a tabular profile that consists of four data tables: general demographics, selected social characteristics, economic characteristics, and housing characteristics. Also, a text-based narrative of the data found in the tables is provided for easy analysis. The Profiles can be found on the Census Bureau's Web site at http://www.census.gov/acs/www/.

2000 Data Profiles
2001 Data Profiles

Change Profiles

"Change profiles" compare estimates of demographic, social, economic, and housing characteristics for previous years. These "change profile" tables were created for the United States, all states, and areas of 1,000,000 population or more.

2000-2001 Change Profile Tables

2000 Summary Tables and 2001 Summary Tables

The 2000 Summary Tables and the 2001 Summary Tables include estimates of demographic and economic characteristics of people, households, and housing units for areas with a population of 65,000 or more in the 31 comparison sites. The tables include housing units, both occupied and vacant. The 42 tables in the 2000 Summary Tables and 2001 Tables present data on the older population as described below:

Number	Table Title
P4	Sex by Age
P5 A-K	Sex by Age
P16	Household by Age of Householder by Household Type (Including Living Alone) by Presence of Own Children Under 18 Years
P17	Household Type by Age of Householder
P18 A-K	Age of Householder
P19	Households by Presence of People 60 Years and Over by Household Size by Type
P20	Households by Presence of People 65 Years and Over by Household Size by Household Type
P56 A-K	Sex by Age by Armed Forces Status by Veteran Status for the Population 18 Years and Over
P59	Sex by Age by Disability Status by Employment Status for the Civilian Noninstitutional Population 5 and Over
P60	Sex by Age by Disability Status by Poverty Status for the Civilian Noninstitutionalized Population 5 Years and Over
P72	Age of Householder by Household Income in the Past 12 Months (In 2000 Inflation-Adjusted Dollars)
P73	Median Household Income in the Past 12 Months (In 2000 Inflation-Adjusted Dollars) by Age of Householder
P74	Aggregate Household Income in the Past 12 Months (In 2000 Inflation-Adjusted Dollars) by Age of Householder
P94	Receipt of Food Stamps in the Past 12 Months by Presence of People 60 Years and Over for Households
P98	Participation in Federal Home Heating and Cooling Assistance Program in the Past 12 Months by Presence of People 60 Years and Over for Households
P114	Poverty Status in the Past 12 Months by Sex by Age
P115 A-K	Poverty Status in the Past 12 Months by Age
P118	Poverty Status in the Past 12 Months by Household Type by Age of Householder
P150	Imputation of Employment Disability for the Civilian Noninstitutionalized Population 16 to 72 Years
PCT9	Nonfamily Households by Sex of Householder by Living Alone by Age of

	Householder
PCT10	Family Type by Age of Householder
PCT 13	Sex by Marital Status by Age for the Population 15 Years and Over
PCT33	Sex by Age by Educational Attainment for the Population 18 Years and Over
PCT37	Sex by Age by Types of Disability for the Civilian Noninstitutionalized Population 5 Years and Over
PCT38 A-K	Age by Types of Disability for the Civilian Noninstitutionalized Population 5 Years and Over with Disabilities
PCT39 A-K	Sex by Age by Disability Status by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over
PCT40	Sex by Age by Sensory Disability by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over
PCT41	Sex by Age by Physical Disability by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over
PCT42	Sex by Age by Mental Disability by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over
PCT43	Sex by Age by Self-Care Disability by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over
PCT44	Sex by Age by Go-Outside-Home Disability by Employment Status for the Civilian Noninstitutionalized Population 16 Years and Over
PCT45	Sex by Age by Employment Disability by Employment Status for the Civilian Noninstitutionalized Population 16 to 72 Years
PCT47	Sex by Age by Employment Status for the Population 16 Years and Over
PCT48 A-K	Sex by Age by Employment Status for the Population 16 Years and Over
PCT51 A-K	Age of Householder by Household Income in the Past 12 Months (In 2000 Inflation-Adjusted Dollars)
PCT53	Aggregate Family Income in the Past 12 Months (In 2000 Inflation-Adjusted Dollars) by Family Type and Age of Householder
PCT55	Median Nonfamily Household Income in the Past 12 Months (In 2000 Inflation-Adjusted Dollars) by Sex of Householder by Living Alone by Age of Householder
PCT56	Aggregate Nonfamily Household Income in the Past 12 Months in 2000 Inflation-Adjusted Dollars by Sex of Householder by Living Alone by Age of Householder
PCT61 A-K	Poverty Status in the Past 12 Months by Sex by Age
PCT64	Poverty Status in the Past 12 Months of Unrelated Individuals 15 Years and Over by Sex by Age
H10	Tenure by Age of Householder
H16	Tenure by Household Type (Including Living Alone) and Age of Householder
H18	Tenure by Age of Householder by Occupants Per Room
H40	Tenure by Telephone Service Availability by Age of Householder
H42	Tenure by Vehicles Available by Age of Householder
H52	Age of Householder by Meals Included in Rent
H76	Aggregate Value (Dollars) by Age of Householder

H90	Age of Householder by Selected Monthly Owner Costs as a Percentage of Household Income in the Past 12 Months
HCT2	Tenure by Household Size by Age of Householder
HCT11	Tenure by Poverty Status in the Past 12 Months by Age of Householder

Summary Tables can be found on the Census Bureau's Web site at http://factfinder.census.gov/servlet/BasicFactsServlet.

Microdata

Public Use Microdata (PUMS) files contain records for a sample of all housing units, with information on the characteristics of each unit and the people in it. All identifying information is removed to ensure confidentiality. The records selected are a sample of those households that received the ACS questionnaire. The questionnaire included questions on age, sex, tenure, income, education, language spoken at home, journey to work, occupation, condominium status, shelter costs, vehicles available, and other subjects. PUMS data can be found on the Census Bureau's Web site at http://www.census.gov/acs/www/Products/PUMS/index.htm.

PUMS for Census 2000 Supplementary Survey
PUMS for 2001 Supplementary Survey

Ranking Tables

Ranking tables were created to give a visual, quick review of comparative data on key issues across states, counties, and places. One ranking table on the older population was released in 2001: E05, Percent of 65 Years and Over Below Poverty Level.

Ranking tables can be found on the Census Bureau's Web site at http://www.census.gov/acs/www/Products/Ranking/Ranking2.htm.

III. DATABASE ON AGING/NATIONAL INSTITUTE ON AGING PRODUCTS

The following reports, articles, and book chapters are based on information in the International Data Base on Aging and other related holdings of the International Programs Center, Population Division, Census Bureau. This work is carried out with the support of the National Institute on Aging and is intended to highlight the trends in global aging and give a better understanding of the effects of population aging within and across national borders.

International Data Base/National Institute on Aging Products

An Aging World: 2001 ..... P95/01-1
"Sex Ratios and Marital Status" in *Aging Clinical and Experimental Research* ..... Vol. 14, No.6, December, 2002
"Living Arrangements" in *Aging Clinical and Experimental Research* ..... Vol. 14, No. 6, December, 2002
"Life Expectancy and Changing Mortality" in *Aging Clinical and Experimental Research* ..... Vol. 14, No. 5, October, 2002
"Health and Disability" in *Aging Clinical and Experimental Research* ..... Vol. 14, No. 5, October, 2002
"The Demographic Dimensions of Aging" in *Aging Clinical and Experimental Research* ..... Vol. 14, No. 3, June, 2002

IV. THE FEDERAL INTERAGENCY FORUM ON AGING-RELATED STATISTICS

The Census Bureau is one of the convening agencies in the Federal Interagency Forum on Aging-Related Statistics. The Forum, begun in the mid-1980s, was the first-of-its-kind effort to coordinate data and efforts of different government agencies. The Forum is currently being managed by staff of the National Center for Health Statistics, with the support of the National Institute on Aging.

The Forum encourages cooperation among federal agencies in the development, collection, analysis, and dissemination of data pertaining to the older population. Through coordinated approaches, the Forum extends the use of limited resources among agencies through joint problem solving, identification of data gaps, and improvement of statistical information bases on the older population that are used to set project priorities of individual agencies.

The Forum goals include widening access to information on the older population, promoting communication between data producers and public policymakers, coordinating the development and use of statistical databases among relevant federal agencies, identifying information gaps/data inconsistencies, and evaluating data quality. The work of the Forum facilitates the exchange of information about needs at the time new data are being developed or changes are being made in existing data systems. It also promotes communication between data producers and policymakers.

V. OTHER PRODUCTS

American Housing Survey

Computer tapes and CD-ROMs are available for the 2001 survey. The survey is designed to provide information on the housing situation in the United States. Information is available by age.

Current Population Survey and Survey of Income and Program Participation

Data for both surveys are available in electronic media.

Statistical Abstract of the United States

As the National Data Book, this annual publication contains an enormous collection of statistics on social and economic conditions in the United States. Selected international data also are included. The Abstract appears in print and CD-ROM versions. It also is available on the Census Bureau's Web site at http://www.census.gov/statab/www/.

Statistical Abstract of the United States: 2001
Statistical Abstract of the United States: 2002

International Data Base

The International Data Base (IDB) is a computerized data bank containing statistical tables of demographic and socioeconomic data for all countries of the world. Most demographic information comes from country-specific estimates and projections made by the Census Bureau's International Programs Center. Country-specific data on social and economic characteristics are obtained from censuses and surveys or from administrative records. Country files are regularly updated as new information becomes available. Selected information from the IDB is highlighted in the Census Bureau's various international reports and publications mentioned previously.

ITEM 3—DEPARTMENT OF DEFENSE

HEALTHCARE

During this reporting period, the Floyd D. Spence National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2001 significantly changed the healthcare coverage offered by the Department of Defense to its Medicare-eligible beneficiaries. The NDAA for FY2001 directed the implementation of TRICARE For Life and the TRICARE Senior Pharmacy Program, which are the most dramatic modifications to military health care coverage since the establishment of the Civilian Health and Medical Program of the Uniformed Services in 1965.

TRICARE is the health plan for uniformed services beneficiaries. It is a regionally organized managed care program that integrates the military health facilities of the Army, Navy and Air Force and supplements the care that these facilities offer with civilian networks of providers.

Prior to the NDAA for FY2001, the Department of Defense sought ways to enhance its services to its age 65 and over beneficiaries through four demonstration programs: TRICARE Senior Prime, the Federal Employees Health Benefits Demonstration Program, the TRICARE Senior Supplement Demonstration and MacDill 65. These programs tested alternatives to expand healthcare coverage to Medicare-eligible beneficiaries through Medicare reimbursement of military treatment facilities, opening access to the Federal Employees Health Benefits Program, expanding pharmacy options, and offering supplemental coverage to Medicare. More than 44,000 beneficiaries participated in these programs. Many of the demonstration programs' benefits were incorporated into the implementation of TRICARE For Life and the TRICARE Senior Pharmacy Program.

On April 1, 2001, the Department of Defense began offering senior beneficiaries age 65 and over a prescription drug benefit through the TRICARE Senior Pharmacy Program. Through this program, eligible beneficiaries may use the mail order pharmacy program, network retail and non-network retail pharmacies. Beneficiaries who turned 65 before April 1, 2001, do not have to be enrolled in Medicare Part B to receive benefits under the TRICARE Senior Pharmacy Program. Those who turn 65 on or after April 1, 2001, must be enrolled in Medicare Part B in order to use the mail order and retail pharmacy benefits under this program. Medications through the mail order and retail pharmacies require a nominal copayment of $3 for generic and $9 for branded medications; by mail order, patients may receive up to a 90-day supply for this amount, and in the network retail pharmacies they may receive up to a 30-day supply for this amount. The non-network retail phar-

macies cost a bit more. In addition to the TRICARE Senior Pharmacy Program, senior beneficiaries age 65 and over may continue to use the military pharmacies at no cost to them, as they did before the new pharmacy program was implemented. Between April 1, 2001, and July 31, 2003, more than 39 million prescriptions have been filled for our Medicare-eligible beneficiaries at a value of approximately $2.1 billion.

Beginning October 1, 2001, TRICARE For Life was implemented as a secondary payer program to Medicare. In most cases, TRICARE For Life beneficiaries have no additional payments or claims to process. To participate, these beneficiaries must be eligible for Medicare Part A and enrolled in Medicare Part B. They may continue to seek care from their Medicare providers and have TRICARE pick up the cost of their deductible, co-payments and other costs not paid by Medicare. TRICARE also covers any TRICARE benefit that Medicare does not offer. Out-of-pocket expenses for these beneficiaries include a nominal co-payment for medications and Medicare Part B fees. TRICARE For Life brings to the senior military retirees and their eligible dependents a health benefit that is unparalleled. It provides low-cost access to an extraordinary range of healthcare benefits, and offers choice in selection of providers. Since October 1, 2001, TRICARE For Life has received more than 63.1 million claims from more than 1.7 million individual beneficiaries. To date (September 8, 2003) during fiscal year 2003, 33.1 million claims have been field. As of August 2003, claims this fiscal year total approximately $1.1 billion for Medical/Surgery (not including all adjustments).

The National Defense Authorization Act for Fiscal Year 2002 provided direction to the Department for a skilled nursing facility benefit and prospective payment system that would align with the Medicare benefit and payment system. We anticipate implementation of the Defense program in the 2003.

For beneficiaries under age 65, TRICARE offers three choices for health care delivery: TRICARE Prime, TRICARE Extra, and TRICARE Standard.

TRICARE Prime, a voluntary enrollment option, offers patients the advantage of primary care management, assistance in making speciality appointments, and additional preventive and primary care services. For eligible beneficiaries, TRICARE Prime is generally the least expensive option.

TRICARE Extra allows eligible beneficiaries to receive an out-of-pocket discount when using preferred network providers. Eligible beneficiaries who do not enroll in TRICARE Prime may participate in Extra on a case-by-case basis just by using network providers. Beneficiaries selecting TRICARE Extra do incur deductibles and co-payments.

TRICARE Standard offers comprehensive healthcare coverage from any authorized provider. Beneficiaries selecting this option incur deductibles and co-payments at a slightly higher rate than those selecting TRICARE Extra.

All active duty members enroll in TRICARE Prime without cost to the member. Family members, survivors and retirees under the age of 65 may enroll in TRICARE Prime. Retirees and their family members pay a small enrollment fee and incur nominal co-pay-

ments for care received from network providers. Care received in military treatment facilities is without cost to beneficiaries; for those not enrolled in TRICARE Prime, care in military treatment facilities is received on a space-available basis.

FEDERAL CIVILIAN PROGRAMS

There are a number of Federal government-wide programs and flexibilities in place that are designed to support aging employees in the workplace and in preparation for retirement as well as to assist employees in concurrently managing their elder care and work responsibilities. In addition, many Department of Defense (DoD) Agencies provide tailored local programs. Below is a description of some of the Federal and DoD unique programs and flexibilities.

Government-wide Programs

Elder Care.—The average of a Department of Defense (DoD) civilian employee is 46.5 years and the average of the Federal full-time civilian employee is 45.6 years. Moreover, an increasing number of these employees face the challenges and responsibilities of caring for an aging family member or friend. To assist employees in carrying out this task, the Office of Personnel Management developed a *Handbook of Elder Care Resources for the Federal Workplace.* This handbook was developed to introduce employees and their agencies to the various services and resources that are available to help individuals make informed elder care decisions. From choosing an assisted living arrangement to dealing with the complexities of social security income, this Handbook provides practical tips and solutions to these complicated aging issues.

The Handbook describes a variety of community resources that are offered around the country to help older adults function independently and discusses housing options, financial and medical considerations, nursing homes, and home health care agencies. It also provides a listing of:

- Federal and National Elder Care Organizations;
- Area Agencies on Aging; and
- State Long-Term Care Ombudsman Offices.

The handbook is available at http://www.opm.gov/wrkfam/elder02.asp.

Alternate Work Schedule.—Alternate Work Schedule (AWS) programs enable managers and supervisors to meet their program goals while, at the same time, allowing employees more flexibility in scheduling their personal activities. AWS programs encompass both flexible work schedules and compressed work schedules. AWS programs allow employees to compress their work hours into eight or nine days of a 10-day work period. This permits employees to have one or two off-days during a pay period. Flexible work schedules permit employees to report to work at any time within a specific time period. Both compressed and flexible work schedules allow employees to gain greater control over their time. Employees can use that time to balance work and family responsibilities more easily, become involved in volunteer activities, and take advantage of educational opportunities.

Telework.—Telework is an alternative work arrangement for employees to conduct all or some of their work away from the primary

workplace. The work location might be a residence, a telecenter, an office closer to the employee's residence, or another acceptable location. The telework schedule may be fixed or episodic. Telework programs allow eligible employees to participate in telecommuting to the maximum extent possible without diminished employee performance. Telework allows employees greater flexibility to balance their personal and professional duties. It also allows both management and employees to cope with the uncertainties of potential disruptions in the workplace.

Long Term Care.—The Federal Long Term Care Insurance (FLTCI) Program was implemented in 2002. This program allows employees, retirees and their eligible family members to include spouses, parents, parents-in-law and stepparents to purchase insurance at group rates to cover the costs of care needed for individuals with ongoing illnesses or disabilities. It also provides coverage for care needed by those with severe cognitive problems like Alzheimer's disease. FLTCI provides reimbursement for care provided by home health care aids, as well as care provided in a nursing home or assisted living facility. Employees who apply for and are approved for coverage can use the program to help them coordinate care for elderly relatives, receive discounts on certain long term care services or supplies, and provide advice and support to the employee as caregiver.

Retirement.—Federal employees are covered under either the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS) depending on when they entered Federal service.

- CSRS is a defined benefit system that provides full retirement benefits at age 55 with 30 years' of service, at age 60 with 20 years' service, or at age 62 with at leave five years' service. Involuntary retirement can occur with reduced benefits at any age after 25 years' service, or at age 50 with 20 years' service. In such cases, an employee's annuity is normally reduced by 2 percent for each year under age 55. An employee contributes 7.0 percent of pay to the CSRS. Annuity benefits are based on an average of the highest three years of salary. The annuity formula provides for 1.5 percent of average salary for the first five years of service, 1.75 percent of average salary for the next five years, and 2 percent per year for any remaining service up to a maximum 80 percent of average salary.
- FERS is a three-tiered plan consisting of a defined benefit element, social security, and thrift savings plan (TSP). The defined benefit element under FERS is calculated using 1 percent of the employee's highest average pay over a three-year consecutive period multiplied by the number of years' of service. If the employee retires at age 62, or later, with at least 20 years of service, a factor of 1.1 percent is used rather than 1 percent. Employees who retire before age 62 qualify for a Special Retirement Supplement that equals the Social Security benefit they will receive upon reaching age 62. This benefit is eliminated once Social Security is received. FERS employees contribute 7.65 percent toward their defined benefit element and Social Security with option to contribute more towards TSP. Agency contributions to an employee's TSP account

amount to 1 percent of basic pay for each pay period. Employees can contribute up to 13 percent of their salary into TSP with agency matching funds up to 4 percent. Employees are eligible to retire with 30 years of service.

Thrift Savings Plan.—The Thrift Savings Plan is a retirement and savings plan for Federal employees and military members. The program is similar to the 401(k) programs offered by many private corporations. The program allows individuals to contribute a percentage of their salary tax-deferred to a savings plan that is managed by a proficient and well-managed government organization. The earnings on the TSP contributions are allowed to grow tax deferred.

- Employees covered by the Federal Employees Retirement System (FERS) receive, each pay period, an automatic contribution to their thrift savings account equal to one percent of their basic pay. In addition, the agency provides matching contributions, dollar-for-dollar for the first three percent of salary that employees invest, and 50 cents on the dollar for the next two percent of salary invested.
- The government match for FERS employee contributions is considered quite generous and has resulted in enhanced recruiting and retention within the Department of Defense. Many experienced mid-career individuals, who might otherwise not consider a Federal career, have accepted Federal positions because of the government contribution and matching TSP payments. Participants in the program are able to amass significant retirement savings that they might not otherwise accrue. At retirement individuals have several options for receiving their account balances or they may leave their TSP funds in the program until age 70½, at which point they must begin making withdrawals under Internal Revenue Service rules for tax-deferred retirement savings plans.

DoD Programs

Some DoD agencies such as the Air Force, Navy, Army and Air Force Exchange Service, Defense Threat Reduction Agency, Defense Logistics Agency, Defense Security Service, Uniformed Services University of the Health Sciences supplement the Federal Programs mentioned above with local programs and activities such as Eldercare fairs/seminars; monthly support groups with guest speakers who talk about adult care, medicare/medicaid, retirement and estate planning; Employee Assistance/Referral programs dedicated to assisting employees with elder care problems; flexible work schedules to better accommodate individual elder care needs; and, retiree councils and transition services.

Air Force developed a comprehensive Eldercare section on the Air Force Crossroads website. (See http://www.afcrossroads.com/html/eldercare/index.cfm.) The site was developed for older adults, concerned family members, or for those interested in the issues of eldercare and the elderly. The website includes information on topics ranging from Alzheimer's to Social Security. The website includes hyperlinks to National Hotlines, Eldercare organizations, resources available to the elderly, State contacts, and other selected sources related to aging.

Defense Logistics Agency's (DLA) Quality of Life, Family Support Program offers a robust eldercare program to meet the needs of DLA military and civilian employees. DLA Life Connections, provided through Federal Occupational Health and the company Life Care.com, helps employees to more effectively manage their life events, to include a wide range of eldercare issues. Convenient for DLA employees, DLA Life Connections services are available 24 hours a day, seven days a week by either a 1–800 number answered by a professional-staffed call center or through internet web access. In addition to online tools, there are educational resources including printed material and kits to help manage eldercare issues. DLA Life Connections services include:

- Searches for elder care resources nationwide including home health care agencies, long-term care facilities, assisted living centers, and hospice care;
- Information on retirement communities;
- Information for caregivers including assessing the needs of a loved one, evaluating care options, home safety for seniors, respite care and more;
- Checklists to help individuals evaluate eldercare facilities and providers;
- A disease and conditions index that enables users to access information on diseases that affect seniors;
- Information on financing care including government-sponsored programs such as Medicare, Medicaid, Social Security, as well as private-pay options. Referrals are provided for Elder Law Attorneys, Hospice Facilities, Hospice Home Care and Funeral Services;
- Educational materials on Retirement and Estate Planning, Helping Others Cope with Grief, Helping Children Cope with Grief, Grief and Bereavement, Funerals: A Consumer's Guide; and
- Information on organizing personal affairs, powers of attorney, healthcare treatment directives, living wills, estate planning, and wills and trusts.

Upon request, DLA Life Connections provides a popular adult care kit, which helps people manage eldercare issues. The kit contains helpful information and products designed specifically to help seniors or their family members manage their daily living.

In addition to the services available through DLA Life Connections, the Quality of Life Family Advocacy Program (FAP) offers workshops and sessions that vary widely to fit the needs of DLA's diverse population. These sessions include information on recognizing and preventing elder care abuse, protecting the elderly, communicating with the elderly and adult development. Subjects of other workshops include Alzheimers, dementia, elder care law, and Grandparents Raising Grandchildren that explores and addresses the challenges and needs faced by grandparents raising grandchildren. The Family Advocacy Program also sponsors a caregivers support group that meets quarterly at which numerous eldercare topics are discussed.

The Defense Distribution Depot Susquehanna, Pennsylvania (DDDSP) FAP offers monthly one-hour sessions for the military and DoD civilian community on eldercare issues. A FAP-contracted

eldercare expert who is on the Social Work faculty of a nearby college conducts these sessions, which vary from open-ended to topic-driven. Occasionally, guest speakers like elder law attorneys, financial planners, or funeral directors supplement these sessions. In addition to marketing these offering, the DDDSP FAP maintains a resources library of eldercare materials to assist personnel with their care giving challenges.

Uniformed Services University of the Health Sciences (USUHS) has some unique benefits available to employees covered under its Administratively Determined (AD) pay system. The following are some of the benefits that are of particular interest to the aging:

- Faculty Retirement System. Specifically, USUHS has a 403(b) retirement system similar to TSP, except that the University contributes 10 percent of the employee's salary. The retirement age and provisions mirror those of an IRA. One provision of this retirement system is a Salary Reduction Agreement (SRA), which allows an AD employee covered under TIAA–CREF or Fidelity to make additional voluntary tax-deferred contributions to his/her retirement or investment accounts through the SRA. Employees covered under FERS or CSRS are not eligible.
- Long Term Disability: An AD employee covered under TIAA–CREF or Fidelity is covered under the Long Term Disability Insurance plan. The employer and the employee share the cost (Agency pays 50 percent & the employee pays 50 percent of the premium). Employees covered under FERS or CSRS are not eligible.
- Continued Academic Affiliation after Retirement: The University allows employees who have retired to continue to participate and contribute to the University as emeritus faculty. USUHS provides office and laboratory space for these individuals and other administrative support. Many retired faculty have chosen to volunteer time at the University to remain productive by providing research, mentoring, and lecturing.
- USUHS, as a Health Sciences University conducts research and makes this research available to the public. In addition, USUHS periodically holds public seminars and lectures on a wide variety of health-related topics such as diabetes, hypertension and weight management.

ITEM 4_DEPARTMENT OF EDUCATION

ENFORCEMENT OF THE AGE DISCRIMINATION ACT OF 1975
CALENDAR YEARS 2001-2002

I. Status of the Department of Education's Implementing Regulation

The Department of Education's final regulation implementing the Age Discrimination Act of 1975 was published on July 27, 1993. The effective date of implementation was August 26, 1993.

The Department's regulation prohibiting age discrimination applies to all elementary and secondary schools, colleges and universities, public libraries, and vocational rehabilitation services. It covers age discrimination at these institutions except age discrimination in employment.

The regulation describes the standards for determining age discrimination; the responsibilities of recipients; and procedures for enforcing the statute and regulation.

II. Age Discrimination Act Implementation

The Department of Education's (ED) Office for Civil Rights (OCR) is responsible for enforcement of the Age Discrimination Act of 1975 (the Age Act), as it relates to discrimination on the basis of age in federally funded education programs or activities. The Age Act applies to discrimination at all age levels. The Age Act contains certain exceptions that permit, under limited circumstances, continued use of age distinctions or factors other than age that may have a disproportionate effect on the basis of age.

The Age Act excludes from its coverage most employment practices, except in federally funded public service employment programs under the Workforce Investment Act of 1998 (formerly the Job Training Partnership Act). The Equal Employment Opportunity Commission (EEOC) has jurisdiction under the Age Discrimination in Employment Act of 1967 to investigate complaints of employment discrimination on the basis of age. OCR generally refers employment complaints alleging age discrimination to the appropriate EEOC regional office. However, the EEOC does not have jurisdiction over cases alleging age discrimination against persons under 40 years of age. Rather than referring such a case to the EEOC, OCR closes the complaint and informs the complainant that neither OCR nor the EEOC has jurisdiction.

The Department of Health and Human Services (HHS) published a general government-wide regulation on age discrimination. Each agency that provides Federal financial assistance must publish a final agency-specific regulation. On July 27, 1993, ED published in the Federal Register its final regulation implementing the Age Act.

Under ED's final regulation, OCR forwards complaints alleging age discrimination to the Federal Mediation and Conciliation Service (FMCS) for attempted resolution through mediation. FMCS has 60 days after a complaint is filed with OCR in which to mediate the age-only complaints or the age portion of multiple-based complaints. ED's regulation provides that mediation ends if: (1) 60 days elapse from the time the complaint is received; (2) prior to the end of the 60-day period, an agreement is reached; or (3) prior to the end of the 60-day period, the mediator determines that agreement cannot be reached.

If FMCS is successful in mediating an age-only complaint or the age portion of a multiple-based complaint within 60 days, OCR closes the case or the age portion of the complaint. If mediation is unsuccessful, the mediator returns the unresolved complaint to ED for further case processing.

OCR helps its working relationship with FMCS by designating enforcement office contact persons who coordinate directly with FMCS. OCR also accepts verbal or facsimile referrals from FMCS after unsuccessful attempts at mediation, and may grant FMCS extensions of up to 10 days beyond the 60 day mediation period on a case-by-case basis when mediated agreements appear to be forthcoming.

The other statutes which OCR enforces are Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin; Title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex; and Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990, which prohibit discrimination on the basis of disability.

In addition, as of January 8, 2002, OCR enforces the Boy Scouts of America Equal Access Act. Under the Act, no public elementary school, public secondary school, or state or local education agency that provides an opportunity for one or more outside youth or community groups to meet on school premises or in school facilities before or after school hours shall deny equal access or a fair opportunity to meet, or discriminate against, any group officially affiliated with the Boy Scouts of America or any other youth group listed in Title 36 of the United States Code as a patriotic society.

III. Complaints

(a) Receipts

OCR received 418 age complaints in Calendar Years 2001-2002. Of these, 122 were age-only complaints and 296 were multiple bases complaints. As shown on Table 1, 229 of the 418 receipts were processed in OCR and 189 were referred to other Federal agencies for processing. The most frequently cited issues in complaint

receipts involving students were "student rights-retaliation/harassment," "academic evaluation/grading," "discipline," "selection for enrollment," "treatment," and "financial assistance/scholarships." The most frequently cited issues in complaint receipts involving employees were "hiring" and "demotion/dismissal/disciplinary action."

TABLE 1: CALENDAR YEARS 2001- 2002
AGE-BASED COMPLAINT RECEIPTS

Processed by OCR	229
Referred to FMCS	127
Referred to EEOC	55
Referred to Other Federal Agencies	7
Total Receipts	418

(b) Resolutions

During Calendar Years 2001-2002, OCR resolved 419 age-based complaints, including 126 age-only complaints and 293 multiple-based age complaints. The resolution of the complaints are shown in Table 2.

TABLE 2: CALENDAR YEARS 2001-2002 *AGE-BASED COMPLAINT RESOLUTIONS*	
Inappropriate for OCR Action	312
OCR Facilitated Change	15
No Change Required	92
Total Resolutions	419

Inappropriate for OCR Action

Of the 419 complaint resolutions, 312 were resolved because they were "Inappropriate for OCR Action." These would include a resolution achieved by (1) referral of a complaint to another federal agency; (2) lack of jurisdiction over recipient or allegation contained in a complaint; (3) complaint was not filed in a timely manner; (4) complaint did not contain sufficient information necessary to proceed; (5) complaint contained similar allegations repeatedly determined by OCR to be factually or legally insubstantial or were addressed in a recently closed OCR complaint or compliance review; (6) subject of a complaint was foreclosed by previous decisions by federal courts, Secretary of Education, Civil Rights Reviewing Authority, or OCR; (7) there was pending litigation raising the same allegations contained in a complaint; (8) allegations were being investigated by another federal or state agency or through a recipient's internal grievance procedures; (9) OCR treated the complaint as a compliance review; (10) allegation(s) was moot and there were no class implications; (11) complaint could not be investigated because of death of the complainant or injured party or their refusal to cooperate; and (12) complaint was investigated by another agency and the resolution met OCR standards.

OCR Facilitated Change

There were 15 complaints resolved because "OCR Facilitated Change." These would include a resolution achieved by (1) a recipient resolving the allegations contained in the complaint; (2) OCR facilitating resolution between the recipient and complainant through Resolution between the Parties; (3) OCR negotiating a corrective agreement resolving a complainant's allegations; and (4) settlement achieved after OCR issued a letter of findings.

No Change Required

In 92 complaints, there was "No Change Required." These would include a resolution achieved by (1) complainant withdrawing his or her complaint without benefit to the complainant; (2) OCR determining insufficient factual basis in support of complainant's allegations; (3) OCR determining insufficient evidence to support a finding of a violation; and (4) OCR issuing a no violation letter of findings.

Literacy Education for Senior Adult Learners

Background

Based on 2000 data, the U.S. Census Bureau estimates that more than 35 million people age 60 or older live in the United States, accounting for approximately 15 percent of the total population. Racial diversity will increase during the next 50 years. In 1998, 67 percent of older Americans had high school diplomas, and 15 percent had obtained at least a bachelor's degree. In 1950, only 18 percent had diplomas and 4 percent had at least a four-year degree. In 2000, the fastest growing segment of the working population was workers 55-64, and the number of workers ages 16-24 is dropping. The older population is growing and will become an increasing percentage of the total learners we serve, so attention should be given to their needs. Moreover, with people living longer, and maintaining healthier lives, it makes more sense than ever to help older persons learn life-enhancing basic skills, according to *Committee for Economic Development,* January 2000.

Overview

The federally funded, State-administered adult education program authorized under the Adult Education and Family Literacy Act, Title II of the Workforce Act of 1998 (Public Law 105-220) (AEFLA) provides funds to the 50 States, the District of Columbia, Puerto Rico and outlying areas. The Workforce Investment Act (WIA) focuses on streamlining services, increasing program quality, enhancing accountability, and allowing more flexibility for local and State programs. The Adult Education and Family Literacy Act was created to provide a partnership among the Federal government, States and localities to assist adults in 1) becoming literate and obtaining the knowledge and skills necessary for employment and self-sufficiency; 2) obtaining the educational skills to become full partners in the educational development of their children; and 3) completing a secondary school education. AEFLA is the Department's major legislated program that supports and promotes services to educationally disadvantaged adults.

Formula grants are made to designated eligible State agencies. States distribute grant funds to local providers through a competitive, direct and equitable process. Eligible providers include: local educational agencies; community-based organizations; volunteer literacy organizations; institutions of higher education; public or private nonprofit agencies; libraries; public housing authorities; nonprofit institutions; and consortia of any of the above providers.

In program year 2001-2002, more than 2.7 million adult learners were served through the Adult Education and Family Literacy Act programs nationwide. Of these learners, approximately 99,072 or 3.6 percent were 60 years of age or older. Programs are offered to older adults through local education agencies, community colleges, nursing homes, senior centers, private homes, community-based organizations, churches, and libraries and include adult basic education, adult secondary education, and English literacy classes. According to the *Adult Education Annual Performance Reports* for program year 2001-2002, the states with the highest enrollment for adults age 60 years or more were California (26,069), Florida (9,288), South Carolina (8,669), New York (6,267), and Puerto Rico (5,223). States that have concerted efforts to expand services and investment to this population include the District of Columbia, Louisiana, and Wyoming.

State Efforts in Working with Older Learners

The *Adult Education Annual Performance Reports* for program year 2001-2002 indicated that the District of Columbia, Louisiana, and Wyoming are providing some activities to enhance quality program instruction and services to their older adult population. The state activities are listed below:

The **District of Columbia State Education Agency** funded an English Literacy/Civics Education (EL/Civics) collaborative, *Language, ETC and Elders Collaborative,* designed to provide EL/Civic instruction to Hispanic mothers who would not otherwise attend English as a second language classes. It was developed to bridge the intergenerational gap between Hispanic seniors and young children between the ages of three and eight. Also, the University of the District of Columbia Elders Program provided computer literacy to 39 older adults. The computer literacy class used a pre-post computer literacy assessment to measure initial computer knowledge and learning gains.

In **Louisiana,** the number of middle-age adults, age 45-59, represents the largest increase of students served in any age group. That age segment increased 26.6 percent over enrollments in 2000-2001. There was a 19.5 percent increase in the age 60 plus group. The majority of the adult instruction totaled 36 weeks, with a principal focus on basic academic skills and General Educational Development Test preparation. Many sites offered year-round access to adult instruction.

Wyoming integrates the Senior Community Service Employment Program into their One-Stop system. Local Adult Basic Education centers are collaborating with One-Stop centers with a referral process: When a learner comes in to the one-stop center and needs basic education instruction, that individual is referred to the most convenient Adult Basic Education center.

In addition, increased public awareness and the implementation of State Resource Centers and One-Stop Centers are expanding the delivery system for senior adult learners. Where needed, supportive services such as transportation are provided as are outreach activities adapting programs to the life situations and experiences of older persons. Individual learning preferences are recognized and assisted through the provision of information, guidance and study materials. To reach more people in the targeted age range, adult education programs often operate in conjunction with senior citizen centers, nutrition programs, nursing homes, and retirement and day care centers.

Trends and Outlook

A report, *The Older Population in the United States: March 2002,* produced by the Census Bureau, stated that more than one in eight people age 65 and over (4.5 million) were either working or looking for work in 2002. Among those ages 60 to 64, the proportions were 57 percent for men and 44 percent for women. The profile of the older population shows that in 2002, among people 55 and over, 25 percent have not completed high school.

There has been a change in the way that older workers are perceived. The notion of assisting an older worker to retire and enjoy leisure time has shifted to attempting to retain and also to recruit older workers. There has been a movement that adheres to the thinking that with training to maintain, enhance, or update skills, older workers may contribute to organizational productivity and may even surpass younger workers in reliability and consistency. Older adults are now viewed as assets particularly in terms of work ethic, reliability, accuracy, and stability according to *The Older Worker: Myths and Realities No. 18*, by David Stein and Tonette S. Rocco, 2001.

The workplace is ever- changing for the older workers. In earlier years, an employee expected to stay with the same employer starting at a young age and continuing until retirement that usually began from the mid- fifties to 62-65 years of age. Today, the aging population is living longer and healthier lives. So the work life for the new older worker evolves from active employment, temporary disengagement from the workplace and reentry into the same—or a new career.

Currently, the fastest growing segment of the older adult population is in the over age 85 group. This population is expected to continue to grow because technological advances in medical care, an emphasis on prevention and wellness, are allowing people to reach advanced ages.

According to the *National Adult Literacy Survey* (NALS) report, *Literacy of Older Adults in America*, older adults are projected to outnumber those under age 18 by the year 2030. A challenge of our society is to find new and better ways to enhance the opportunities of older adults to live full, independent, and productive lives through their later years.

Educational attainment influences socioeconomic status, and thus can play a role in well-being at older ages. Higher levels of education are usually associated with higher incomes, higher standards of living, and above-average health status among older Americans.

In conclusion, cooperation and collaboration among organizations, institutions and community groups are strongly encouraged at the national, State and local levels to meet the demanding needs of older learners. In addition, States are working on promising practices and accountability measures to strengthen and expand instruction and services for this population.

ITEM 5—DEPARTMENT OF ENERGY

INTRODUCTION

The Department of Energy contributes to a better quality of life for all Americans by ensuring energy security, maintaining the safety, security and reliability of the nuclear weapons stockpile, cleaning up the environment from the legacy of the Cold War, and developing innovations in science and technology. After 25 years in existence, the Department now operates 24 preeminent research laboratories and facilities and four power marketing administrations, and manages the environmental cleanup from 50 years of nuclear defense activities that impacted two million acres in communities across the country. The Department has an annual budget of about $23 billion and employs approximately 14,500 federal and 100,000 contractor employees.

The Department of Energy is principally a national security agency and all of its missions flow from this core mission to support national security. The Department has four strategic goals toward achieving its mission:

- Defense Strategic Goal: To protect our national security by applying advanced science and nuclear technology to the Nation's defense.
- Energy Strategic Goal: To protect our national and economic security by promoting a diverse supply and delivery of reliable, affordable, and environmentally sound energy.
- Science Strategic Goal: To protect our national and economic security by providing world-class scientific research capacity and advancing scientific knowledge.
- Environment Strategic Goal: To protect the environment by providing a responsible resolution to the environmental legacy of the Cold War and by providing for the permanent disposal of the Nation's high-level radioactive waste.

Science and technology are the Department's principal tools in the pursuit of its national security mission. The Department has amassed tremendous scientific and technical capabilities, serving America in ways never anticipated 25 years ago. These capabilities are applied to the overarching mission of ensuring the national security.

ENERGY EFFICIENCY PROGRAMS

Weatherization Assistance Program.—The program's mission is to make energy more affordable and to improve health and safety in homes occupied by low-income families, particularly those with elderly residents, children, or persons with disabilities. Elderly residents make up approximately 40 percent of the low-income house-

holds served by this program. As of September 30, 2002 about 5.4 million homes had been weatherized with federal, state, and utility funds; of these, an estimated 2.2 million were occupied by elderly persons.

Low-income households spend an average 15 percent of income for residential energy—more than four times the proportion spent by higher income households. The weatherization program allows low-income citizens to benefit from energy efficiency technologies that would otherwise be inaccessible to them. Reducing the high energy cost burden faced by low-income Americans helps them increase their financial independence and provides them flexibility to spend household income on other needs.

The Weatherization Assistance Program has become increasingly effective due to improvements in air-leakage control, insulation, water heater systems, windows and doors, and space heating systems. At current prices, a weatherized low-income household now saves approximately $218 per year, about one-third of its space heating costs. Program benefits are further described in the *Progress Report of the National Weatherization Assistance* Program, available through the National Technical Information Service, 703/487–4650, 5285 Port Royal Road, Springfield, VA 22161.

States implement the program through community-based organizations. DOE and its state and community partners weatherize approximately 70,000 single- and multi-family dwellings each year. The program awarded $153 million in Fiscal Year 2001 and $230 million in Fiscal Year 2002 for grants to the 50 states, the District of Columbia, and six Native American tribal organizations. In addition to DOE appropriations, state and local programs receive funding from the Department of Health and Human Services' Low Income Home Energy Assistance Program, from utilities, and from states.

State Energy Program.—The program provides grants to state Energy Offices to encourage energy efficiency and the use of renewable energy technologies and practices in states and communities through technical and financial assistance. In Fiscal Year 2001, $37.5 million was appropriated for the program and in Fiscal Year 2002, $45 million. States have broad discretion in designing their projects. Typical project activities include: public education to promote energy efficiency; transportation efficiency and accelerated use of alternative transportation fuels for vehicles; financial incentives for energy conservation/renewable projects including loans, rebates, and grants; energy audits of buildings and industrial processes; development and adoption of integrated energy plans; promotion of energy efficient residences; and deployment of newly developed energy efficiency and renewable energy technologies.

Some projects target the elderly specifically, such as Louisiana's low-income/handicapped/ elderly/Native American outreach program which provides energy related assistance through a joint venture with utilities. The elderly also benefit from broader programs that provide energy audits, hands-on energy conservation workshops, and low-interest loans for homeowners. These can result in significant personal energy savings. Energy efficiency improvements in local and state buildings and services also indirectly benefit the elderly by freeing up state and local government tax reve-

nues for non-energy needs, as do energy efficient schools which place less of a burden on property taxes.

INFORMATION COLLECTION AND DISTRIBUTION

The Energy Information Administration collects and publishes comprehensive data on energy consumption and expenditures through the Residential Energy Consumption Survey (RECS). The RECS is conducted in households quadrennially and collects data from individual households throughout the country, including those headed by elderly individuals. Along with household and housing unit characteristics data, the RECS also collects the actual billing data from the households' fuel suppliers for a 12-month period.

The results of the RECS are analyzed and published by the Energy Information Administration. The most recent survey data are from the 2001 RECS and are published on the Internet at http://www.eia.doe.gov/emeu/recs. The 2001 RECS public use data files will become available at this site in November 2003. These files will include demographic characteristics of the elderly such as age, marital status, and household income, as well as estimates of consumption and expenditures for electricity, natural gas, fuel oil, kerosene, and liquefied petroleum gas used in elderly households.

In the 2001 RECS, 33.1 million, or 31 percent of all U.S. households, were headed by a person 60 years of age or older. Of these elderly households, 44 percent were one-member households (14.5 million people living alone) and 43 percent contained two people. In 23 percent of the two-member elderly households both members were under the age of 65; in 24 percent of these households, only one member was younger than 65; and in 53 percent, both members were over the age of 65. Comparisons of elderly versus non-elderly households reveal:

- The 2001 household income of elderly households was generally lower than that of non-elderly households. About one-seventh, 15 percent, of elderly households had income of less than $10,000, compared to 9 percent of the non-elderly households. Nearly a quarter, 23 percent, of the elderly households had income of $50,000 or more, compared to 42 percent of the non-elderly households. Of the 15 million U.S. households whose income was below the poverty line, 37 percent were headed by a person 60 years or older.
- Despite having lower household incomes, the aforementioned elderly households were more likely to own their housing unit, 78 percent, than were non-elderly households, 64 percent. The elderly were also more likely to live in a single-family house, 72 percent, than were non-elderly households, 68 percent.
- Elderly households were less likely to have a personal computer or access to the Internet than were households headed by persons less than 60 years of age. Among elderly households, 34 percent had a personal computer compared to 66 percent of the non-elderly households. Only 27 percent of elderly households had access to the Internet compared to 56 percent of the non-elderly households.

• Elderly households were only marginally less likely to have a microwave oven, 84 percent, than are non-elderly households, 87 percent.

Analysis of the 2001 RECS data shows that consumption patterns differed between the elderly and non-elderly for some uses of energy. The elderly used more energy to heat their homes but used less energy for air conditioning, water heating, and lighting and appliances. Expenditures followed the same pattern. Specifically,

• The average expenditures per household member in elderly households in 2001 was $873. This amount was higher than the comparable amount for all other households, due to the fact that households headed by persons 60 years or more are smaller than those headed by persons under 60 years of age. The average size of a household headed by persons 60 years or more was 1.8 persons compared to an average household size of 2.9 persons for those headed by persons under 60 years.

About 53 percent of total energy consumption and about 37 percent of total energy expenditures in elderly households were for space heating. On the other hand, lighting and appliances accounted to 27 percent of consumption and 43 percent of total expenditures in elderly households. Energy costs for lighting and appliances are much higher relative to consumption than are energy costs for space heating because virtually all lights and appliances are powered by electricity, the most expensive energy source, whereas space heating is largely provided by other, less expensive, energy sources.

RESEARCH RELATED TO AGING

During fiscal years (FY) 2001 and 2002, the Office of Environment, Safety and Health (EH) sponsored research to further understand the human health effects of radiation and beryllium exposure. The Department of Energy (DOE) sponsored epidemiologic studies concerned with understanding health changes over time as part of this research program. Lifetime studies of humans constitute a significant part of EH's research; and because the risks of various health effects vary with age, these studies take age into consideration. EH supports research to characterize late-appearing effects induced by chronic exposure to low levels of physical agents, as well as some basic research on certain diseases that occur more frequently with increasing age.

Because health effects resulting from chronic low-level exposure to energy-related toxic agents may develop over a lifetime, they must be distinguished from health effects associated with the normal aging processes. To distinguish between induced and spontaneous changes, information is collected from both exposed and unexposed groups on changes that occur throughout their (**the sentence is vague—if "their" is not the appropriate word—sentence needs to be changed**) life span. These data help characterize normal aging processes and distinguish them from the toxicity of energy-related agents. Summarized below are specific research projects that the Department sponsored during FY 2001 and 2002.

Long-Term Studies of Human Populations.—Through EH, DOE continued to support epidemiologic studies of health effects in humans who may have been exposed to chemicals and radiation asso-

ciated with energy production or national defense activities. Information on life span in human populations is obtained as part of these studies. Because long-term studies of human populations are difficult and expensive, they are initiated on a highly selective basis.

The Radiation Effects Research Foundation, sponsored jointly by the United States and Japan, continues to work on a lifetime followup of survivors of atomic bombings that were carried out in Hiroshima and Nagasaki in 1945. Over 100,000 persons are under observation in this study. An important feature of this study is the acquisition of valuable quantitative data on dose-response relationships. Studies specifically concerned with age-related changes are also conducted. No evidence of radiation-induced premature aging has been observed.

Multiple epidemiologic studies involving about 400,000 contract employees at DOE facilities are being managed by the Department of Health and Human Services through a Memorandum of Understanding between the two agencies. These studies include assessments of health effects at older ages due to ionizing radiation and other industrial toxicants. A recent study indicated that workers who were occupationally exposed to radiation for the first time at age 45 or older might be more sensitive to health effects than workers who were exposed at younger ages. However, very few workers at DOE fit this profile. This finding is very preliminary and further research and analyses are being conducted to see if these results can be duplicated. Several other studies, currently under way, will look closely at workers who were first exposed at age 45 or older, assessing further the potential impact of late exposures in relation to the burden of chronic diseases that are common among older people. The average age of workers included in these studies is greater than 50 years.

The United States Transuranium/Uranium Registry, currently operated by Washington State University, collects occupational data, including work, medical, and radiation exposure histories and information on mortality among workers exposed internally to plutonium or other transuranic elements. Most of the workers participating in this voluntary program are retirees.

In response to the Defense Authorization Act of 1993, EH has established a program involving a number of ongoing projects across the DOE weapons complex to identify former workers whose health may have been placed at risk as a result of occupational exposures that occurred from the 1940s through the 1960s. The projects provide medical screening and monitoring for former workers to identify those at high risk for occupationally related diseases and to identify workers with diseases that may be reduced in severity by timely interventions. Over 30,000 workers have been notified of the availability of these free medical examinations since 1998. Approximately 4,500 workers have participated in the program. Medical screening of former workers at DOE's Paducah, Kentucky and Portsmouth, Ohio gaseous diffusion plants is now under way. Further expansion of medical screening is anticipated at the Oak Ridge, Tennessee Y–12 Plant, Oak Ridge National Laboratory, and among former workers at the Pantex Plant in Amarillo, Texas.

In addition to its epidemiologic research and health monitoring programs, EH maintains the Comprehensive Epidemiologic Data Resource, a growing archive of data sets from the many epidemiologic studies sponsored by DOE. This public archive provides the research community with data that continues to be used to gain additional insights into the relationships between occupational exposures and a variety of health outcomes, including diseases of aging like cancer.

OTHER DOE–FUNDED RESEARCH RELATED TO AGING

Since the inception of the Atomic Energy Commission, the Department and its predecessor agencies have carried out a broad range of research and technology development activities which have impacted health care and medical research. The Medical Sciences Division within the Office of Biological and Environmental Research, Office of Science, carries out a Congressional mandate to develop beneficial applications of nuclear and other energy related technologies, including research on aging.

The Aging Research involves study of a brain chemical, dopamine (DA), and its function in humans as they age. It has long been recognized that age brings a significant decline in the function of the brain DA system, but the functional significance of this loss is not known. Medical imaging studies, using radiotracers and positron emission tomography, are designed to investigate the consequences of age-related losses in brain DA activity in cerebral function and to investigate mechanisms involved with the loss of DA function in normal aging. The results of these studies to date have shown that healthy volunteers with no evidence of neurological dysfunction do experience a decline in parameters of DA function, which are associated with a decline in performance of motor and cognitive functions. The results of these studies also indicate that changes in life style, such as exercise, may be beneficial in promoting the health of the dopamine system in the elderly.

ITEM 6_DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEVELOPMENTS IN AGING: CALENDAR YEARS 2001 and 2002

ADMINISTRATION ON AGING

Introduction

The Administration on Aging (AoA) serves as the Federal focal point and advocate agency for older persons and their concerns. Its mission is to help elderly individuals maintain their independence in the community, even in the face of disability and chronic disease, which can severely affect the well being of the elderly. In its role, AoA works to heighten awareness among other Federal agencies, organizations, groups, and the public about the valuable contributions that older Americans make to the Nation and alerts them to the needs of vulnerable older people. AoA also administers the Older Americans Act (OAA), which through various grant programs supports an array of community-based supportive services, as well as state and local efforts to develop comprehensive and coordinated systems of care for older people and their family caregivers.

AoA oversees the OAA at the Federal level, working especially to coordinate and integrate Federal programs that benefit the elderly. AoA carries out its advocacy and service-delivery programs in collaboration with a national service network that includes 56 State Units on Aging, 655 Area Agencies on Aging, 243 Tribal organizations, over 29,000 local community service organizations, 500,000 volunteers, and a wide variety of national organizations.

Working together, the community-based network provides services in support of the AoA's mission to help elderly individuals maintain their independence in the community, and the results of these efforts are positive. AoA and the network are focused on producing and measuring results that foster the AoA mission, and program data from administrative records and AoA national surveys of OAA clients record the impact of the efforts of AoA and the network.

- OAA programs reach a significant number of elderly individuals. Approximately fifteen percent of elders 60 and over (over 45 million) receive OAA information, meals and support services.
- Services are targeted to those who are vulnerable and need help: the poor, low-income minorities, rural residents, and the disabled. In each fiscal year, approximately 30% of clients are poor; over 50% of minority clients are poor; and about 30% of clients live in rural areas. Over 70% of new home-delivered meals clients are at high nutritional risk.
- States and communities contribute significantly to OAA programs; AoA is the minority funder in this enterprise. States and communities leverage $2 for every $1 in AoA funding. For selected in-home services targeted to disabled elders, they leverage about $3 for every $1 in AoA funding.
- The aging services network can help to keep elderly individuals in the community. Thirty-percent of the network's home-delivered meals and homemaker service clients are nursing-home eligible, but are cared for in the

community.

- Family and friends who care for elders are the nation's most powerful resource in helping the elderly stay at home, and they value OAA services. Over 85% of caregivers of elderly clients surveyed by AoA reported that OAA services help them care longer for their loved ones.
- The network provides services that are useful and necessary for vulnerable elders to remain in the community. The OAA program is the sole source of transportation services for over thirty-percent of all clients who receive the service.
- Elderly clients are overwhelmingly satisfied with the services provided under the OAA. For all services subjected to consumer surveys, including meals, homemaker services, transportation and information services, client satisfaction reported by the elderly was in the range of 90% or higher.

AoA Strategic Action Plan

To continue to focus on and improve the results that the network is producing for older Americans, the Administration on Aging launched a strategic planning process in 2001 that culminated in the adoption of a five year Strategic Action Plan in 2002. The planning process involved broad public input from eight national listening sessions AoA conducted throughout the country in 2001. The AoA Strategic Action Plan established five priorities to promote the dignity and independence of older people and support the leadership role of the Aging Services Network in shaping our evolving health and long term care system. The document is used to inform policy and budget decisions to ensure that the agency's activities are centered around our core value of promoting independence and supporting older people and their family caregivers. This report is organized around the priorities outlined in the Plan.

SECTION I – Making it Easier for Older People to Access an Integrated Array of Health and Social Supports

New Freedom Initiative

One of the most significant keys to producing successful results for elderly individuals is for AoA and other HHS organizations to ensure a coordinated, integrated approach to help elderly individuals remain in the community. Beginning in February 2001, the primary vehicle that HHS has used to advance policy initiatives related to long-term care for older adults and people with disabilities has been the President's New Freedom Initiative. The New Freedom Initiative is a comprehensive plan to remove barriers to community living for people with disabilities by working to ensure that all Americans have the opportunity to learn and develop skills, engage in work, make choices about their daily lives, and participate fully in community life. The Administration on Aging has played a leadership role within the department in supporting the President's New Freedom Initiative.

President Bush issued Executive Order 13217 in June 2001 as one of his first actions to

implement the New Freedom Initiative. The Order committed the federal government to help states eliminate barriers to community living; it directed HHS to coordinate a government-wide effort to identify statutory and regulatory barriers to community living and report on ways to eliminate those barriers. AoA coordinated the public input process called for in the Executive Order. The initiative involved nine federal departments. The process resulted in over 1000 public comments being received, analyzed and reflected in the April 2002 report to the President entitled, *Delivering on the Promise: HHS Self-Evaluation to Promote Community Living for People with Disabilities.*

The Administration on Aging established and chaired an intradepartmental workgroup on informal caregiver support in April 2002. The workgroup focused its efforts on implementing the solutions related to caregiver support outlined in the report to the President. The workgroup was comprised of representatives from nine HHS agencies, including the Administration for Children and Families, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the National Institute on Aging, and the Substance Abuse and Mental Health Services Administration. The first product of the workgroup, completed in December 2002, was the first ever compilation of HHS activities to support caregivers, titled "HHS Compendium of Caregiver Support Activities."

In May 2001, Secretary Thompson announced the first round of "Real Choice Systems Change Grants." A total of $50 million in grant funds was made available, by the Centers for Medicare and Medicaid Services, to the states to support innovative ways to expand and enhance the delivery of home and community-based services. AoA helped to shape the design of this program to ensure these grants could be used to support changes that would benefit the elderly and involved the Aging Services Network. More than three quarters of the first round of Real Choice Grants included the elderly as a target population. State Units on Aging were directly involved in the planning and implementation activities in a majority of the states, and in 5 states, the State Unit on Aging took the lead in implementing a Real Choice Grant.

In May 2002, Secretary Thompson directed AoA to work with the Centers for Medicare & Medicaid Services, the Assistant Secretary for Planning and Evaluation, and the Agency for Health Care Quality and Research on a study that would highlight the role the Aging Services Network has played in helping states and communities to develop more balanced systems of long term care. AoA subsequently commissioned case studies of 14 state models in the areas of integrated access and services, consumer directed care, information technology and consumer involvement in policy and program decision-making and redirecting public long term care resources to create a more balanced system of care. This work is now being finalized; a full report will be issued in 2004.

AoA partnered with the Centers for Medicare & Medicaid Services during 2002 to develop a joint initiative to help states create "one stop shop" access programs that will make it easier for people to learn about and access long term care services. This initiative is known as the Aging and Disability Resource Center Program. The goal of this program is to help people make informed decisions about their service and support

options, and provide consumers with a single entry point to publicly supported long term care programs at the community level. Under the program, States will be able to better coordinate and/or redesign their existing systems of information, assistance and access, which currently involve multiple federal, state and local programs. The initiative builds on the experience of "one-stop shop" programs in Wisconsin and other states. Funding for the Aging and Disability Resource Center Program was included in the President's FY2003 Budget.

Listening Sessions

AoA is committed to producing and measuring results that are directly focused on improving conditions for its primary consumers, the elderly. To foster success in this enterprise, AoA and the network recognize the importance of listening to consumers. In order to solicit the input of those most affected by Older Americans Act, AoA has conducted a series of listening sessions. Eight of these sessions were held in 2001 and 2002. The sessions were held all over the country and were designed to allow participation from consumers, caregivers, service providers, State and Area Agencies on Aging, Native American Tribal Organizations, advisory councils, and representatives of national, state, and local aging organizations.

Tribal Listening Session

The needs of elderly native Americans are unique, and require direct and focused attention. AoA hosted a Tribal Listening Session on August 15, 2001 in Washington, DC with Native American Tribal leaders throughout the country. The Session focused on issues affecting the lives of Indian elders. There were over 100 participants representing Tribes nationally. The Listening Session allowed for an open dialogue addressing four priority areas: 1) policy directions; 2) capacity building; 3) health care; and 4) long-term care. Recommendations were made by the participants in these four areas and are currently being reviewed and addressed.

Interagency Task Force on Older Indians

The OAA directs the Assistant Secretary for Aging to establish a permanent Interagency Task Force on Older Indians. The Task Force meets quarterly and is comprised of representatives of Federal departments and agencies with "an interest in older Indians and their welfare". The Task Force is legislatively mandated to improve services to older Indians. The Director of the Office of American Indian, Alaskan Native and Native Hawaiian Programs chairs this Task Force. The current focus of the Task Force is on health, transportation, and data. Three subcommittees gather and analyze information, make recommendations for action to the Task Force that would further interagency collaboration and enhance services to older Indians, and identify problems that prevent or diminish collaboration.

Intradepartmental Council on Native American Affairs

The Intradepartmental Council on Native American Affairs, authorized by the Native American Programs Act of 1974, as Amended, and reestablished by Secretary Thompson in 2002 serves as the focal point within the Department for coordination and consultation on health and human service issues affecting the American Indian, Alaska Native and Native American population. The membership consists of the heads of HHS Operating Divisions, Staff Division heads, the Director, Office of Intergovernmental Affairs, the Director, Center for Faith-Based and Community Initiatives, the Executive Secretary to the department, and two HHS regional representatives.

Medicare Empowerment and Collaboration Initiative

AoA partnered with the Centers for Medicare and Medicaid Services (CMS) on an initiative aimed at developing and testing approaches for effectively utilizing CMS resources to provide information about Medicare and Medicare+Choice to beneficiaries and their caregivers. The selected 26 projects reached a wide variety of underserved beneficiaries, including Native Americans, African Americans, Latinos, Vietnamese and other Asian populations, and Russians and other Eastern Europeans. For those with mobility and other limitations, a number of projects brought Medicare information directly to the beneficiary's home. Additionally, a wide array of professionals, volunteers and family caregivers received training to enhance their understanding of Medicare programs and CMS resources and many consumer audiences were reached through several projects that involved radio and television public awareness campaigns.

Improving the AoA Website

AoA recognizes the increasing need for government to use the latest technologies to increase the efficiency and effectiveness of its business operations. With this in mind, in November 2002 AoA launched a redesign of its website www.aoa.gov. The goal of the redesign is to create a more professional, coordinated, and streamlined state-of-the-art website that will enhance the public's ability to access aging information. Site now includes an Aging News section that highlights research, funding opportunities, and information that is up-to-date and relevant to older Americans, their caregivers, and professionals. Resource Rooms on key topics such as Alzheimer's Disease and caregiving have been added to make it easier for consumers and professionals to access topic specific information and resources.

The ability to access information in multiple languages is a major enhancement to the website. The site can be translated into eight different languages broadening access to those with limited English proficiency.

Eldercare Locator On-Line

In November 2001, AoA developed a new tool to assist older persons and their

caregivers, especially long-distance caregivers to identify reliable home and community-based services. The Eldercare Locator on-line, www.eldercare.gov, provides users 24-hour access to community assistance resources for seniors. By entering a zip code individuals can access their State and Area Agency on Aging. In addition, the site provides useful information, resources and links. In 2002, the Eldercare Locator averaged over 25,000 users a month.

Alzheimer's Disease Demonstration Grants to States

The Alzheimer's Disease Demonstration Grants to States Program (ADDGS) was established under Section 398 of the Public Health Service Act (P.L. 78-410) as amended by Public Law 101-157 and by Public Law 105-379, the Health Professions Education Partnerships Act of 1998. The ADDGS program's mission is to expand the availability of diagnostic and community-based support services for persons with Alzheimer's disease, their families, and their caregivers. The Administration on Aging provides an added focus of reaching hard-to-serve and underserved people with Alzheimer's disease or related disorders (ADRDs).

The ADDGS projects demonstrate how existing public and private resources within States may be more effectively identified, utilized, and coordinated to enhance the educational and service delivery systems for persons with Alzheimer's disease, their families and caregivers. Under the Program, state grantees develop models of care for persons with Alzheimer's disease, and improve the responsiveness of the home and community based care system for persons with dementia. Specifically, grantees:

- *Link public and non-profit agencies* that develop and operate respite care, and other support, educational, and diagnostic services within the State to people who need services;
- *Deliver services* such as primary health care physician education and support services including respite care, home health care, personal care, day care, companion services, short-term respite care, and other forms of respite and supportive services to persons with ADRDs (at least 50% of the total grant must be spent on these activities);
- *Improve access* to home and community based long term care services for persons with Alzheimer's Disease & their families;
- *Provide individualized and public information,* education, and referrals about 1) diagnostic, treatment and related services that are available; 2) sources of assistance to obtain such services, including entitlement programs; 3) legal rights of individuals and families affected by ADRD.

Each year, AoA holds a competitive grant award process, resulting in the issuance of grants to states. In 2001, AoA had 25 state grantees, while as of July 2002, there were 33 state grantees under the ADDGS program. Each grant has a 3-year project period and requires local match in the amounts of 25% (year 1), 35% (year 2), and 45% (year 3). Grants range from $225,000 to $350,000, with the average federal award averaging approximately $310,000. Projects are targeted to hard-to-reach populations including ethnic minorities, low income and rural families with Alzheimer's disease. In 2002, the 33 states with ADDGS grants included Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wisconsin.

As of July 2002, 42 states plus Puerto Rico and the District of Columbia had been funded under the Alzheimer's Demonstration program. The program is formally evaluated through an university-based contractor, and a report was issued in 2003.

Managed Care Initiative

In addition to these 33 projects, 5 states participated in the ADDGS Managed Care Initiative. The Managed Care Initiative is designed to test the impact of community-based service interventions on primary care physician utilization rates by persons with Alzheimer's disease, and their satisfaction with health care plans in a managed care environment. Final results from the Managed Care Initiative will be available by June 2004.

Organizations participating in the ADDGS Managed Care Initiative are:

- DC Office on Aging
- Florida Department of Elder Affairs
- Michigan Department of Community Health
- Ohio Department on Aging
- Oregon Senior and Disabled Services Division

ADDGS Outcomes

Evaluation Results & Program Achievements

Throughout the program, a university-based evaluation team has independently evaluated ADDGS grantee projects. This analysis of states' experience in developing and delivering health and social support home and community based care services to persons with Alzheimer's disease and their families has generated many findings – findings which have program and policy implications far beyond the ADDGS program. As data on the accompanying chart highlights, the program has been extremely successful in reaching traditionally underserved and hard-to-reach populations including cultural and ethnic minorities, low income and rural families, and person with developmental disabilities who also have Alzheimer's disease.

ADDGS evaluation findings include:

- Almost one-third of the demonstration clients used respite services for only one or two months and the average length of use was ten months.
- Elders with male caregivers used more respite services than those with female caregivers.
- Different ethnic groups had distinct patterns of day care use over time. Hispanics/Latinos and Blacks/African Americans used, on average, the same number of hours of day care. However, African Americans used small quantities of service over an extended period of time, while Hispanic elders used high quantities of service for short periods of time.
- When elders in managed care health plans receive the type of home and community based services provided by AoA, they are more satisfied with their health care plans and appear to use less hospital and emergency room care than when they do not receive AoA services.
- There are 6 overarching keys to successful development of services and systems of care for persons with Alzheimer's disease in diverse communities:
  - Establish trust and credibility within local community.
  - Build community awareness of Alzheimer's disease & available services.
  - Build or expand local service capacity.
  - Create and provide new services.
  - Develop local resources and ownership in program.
  - Stabilize projects and services before starting new ventures.

Profile of Individuals and Caregivers Receiving Support in 2001-2002
thru the
AoA Alzheimer's Disease Demonstration Grants to States Program

Intensive home & community based supports	4,373
Information & education	150,000+
Communities involved in program	400

Age

54 or less	2.1%
55-64	3.8%
65-74	15.5%
75-84	43.5%
85 or more	30.4%
not reported	4.7%
Average age of ADDGS clients	79.7 years

Gender

Women = 63.7% Men = 36.3%

Race/Ethnicity

African American	14.8%
White	48.3%
Hispanic/Latino	22.2%
Asian/Pacific Islander	9.9%
Native American	.5%

Living Arrangement

Live Alone	16.7%
Elder + 1 other	48.7%
Elder + 2 others	26.0%
Not reported	8.7%

Geographic Location

Rural or small town	47.8%
Urban/Large City/Suburb	51.7%
American Indian Reservation	.5%

Household Income

$0 - $14,999	66.7%
$14,999 +	33.3%

Functional Impairments

Average of **4.2** Activities of Daily Living (equal to NF level of care in most states)

SECTION II – Helping Older People to Stay Active and Healthy

Steps to Healthy Aging Initiative

AoA launched the *Steps to Healthy Aging* Initiative in June 2002 in conjunction with the announcement of the President's *HealthierUS Initiative* to ensure that older Americans know about the very simple things they can do to prevent illness such as increasing physical activity and eating healthfully. AoA partnered with the National Policy and Resource Center on Nutrition and Aging at Florida International University to support Steps to Healthy Aging initiative.

Steps to Healthy Aging Initative is a two-part project, Eating Better and Moving More, designed to increase physical activity and improve nutrition in older adults. The Eating Better component of the program is designed to help older Americans make healthful eating choices. The Moving More component encourages simple and fun moderated physical activity by the use of electronic step counters to monitor and increase physical activity in older adults. A *Guidebook for Community Programs* that shows how to plan, design, implement, and evaluate a community-based walking program for individuals and groups has been developed.

Evidence-Based Prevention Program

The Administration on Aging collaborated with the Centers for Disease Control, National Institute on Aging, Agency for Healthcare Research and Quality, Robert Wood Johnson Foundation, and the John A. Hartford Foundation in 2002 to develop an initiative to support the delivery of interventions through the aging services providers that have proven to be effective in reducing the risk of disease and disability among older people. The initiative will demonstrate the Administration on Aging's role in translating findings from research generated by other HHS agencies into practice in the community. Funding for a grant program to implement this initiative was included in the President's FY 2003 budget.

Aging States Project

AoA is partnering with the CDC on *The Aging States Project: Promoting Opportunities for Collaboration between the Public Health and Aging Services Networks*. Initiated in 2001, its goal is to bring together the strengths and expertise of state public health and aging networks to better meet their shared responsibility for ensuring optimal health for our nation's older residents. The Aging States Project has compiled information on health needs, activities, and partnerships related to older adults through a needs assessment questionnaire sent to all state and territorial State Units on Aging (SUAs) and State Health Departments (SHDs). The information collected provides an overview of their current health promotion and disease prevention efforts for older adults. It identifies barriers, program support needs, and the status of collaborations between SUAs and SHDs across the United States. It identifies opportunities to strengthen these collaborations and improve resource use that will better address the health needs of older

adults.

The Aging States Project also seeks to address significant health problems affecting older Americans, such as diabetes, cardiovascular disease, and the need for immunization through four demonstration grants to community coalitions. In addition, AoA in conjunction with CDC issued mini-grants to states to support community collaborative efforts between health departments and aging service network providers around fall prevention, nutrition, physical activity and to encourage caregivers to use preventive heath benefits under Medicare. States who received mini-grants are: Arkansas, California, Iowa, Maine, Maryland, Massachusetts, Michigan, North Carolina, Oklahoma, and Wyoming.

Elderly Nutrition Program

Adequate nutrition is essential for healthy aging, the prevention or delay of chronic disease and disease-related disabilities, and for improved quality of life. The Elderly Nutrition Program, authorized by Titles III and VI of the Older Americans Act, is the largest and most visible federally funded community-based nutrition program for older adults. The purposes of these programs are to improve health, improve dietary intakes, offer participants opportunities to form new friendships, create informal support systems, and link participants to other health and supportive services. The OAA Nutrition Program provides for congregate and home-delivered meals, also known as Meals-On-Wheels. Other services include nutrition screening, assessment, education, and counseling. Linkages to health promotion and disease prevention programs as well as physical activity programs are also critical. These meals and other nutrition services are provided in a variety of settings, such as senior centers, schools, and in individual homes.

To ensure that AoA and the network remained focused on results, AoA gathers service data from the states each year, and has initiated consumer assessment surveys that allow elderly individuals to provide their input on the quality of OAA meals programs. The data show that vulnerable older adults rely heavily on AoA's nutrition programs, and are pleased with the meals.

- The network serves over 250 million meals a year through the nutrition programs.
- Over 90% of the elders who receive congregate meals and/or home-delivered meals, like the meals that are served.
- Almost 80% of home-delivered meals clients are at high nutritional risk.
- States and communities serve over 1.7 million older individuals in congregate meals sites each year.

30th Anniversary of the Older Americans Act Nutrition Program

In 2002, AoA and the nation celebrated its 30th anniversary of the nutrition program, the largest community-based nutrition services program for older adults in the country. The AoA highlighted 30 years of progress in nutrition programs across the country emphasizing the community nature of the program. The President of the United States,

George W. Bush sent greetings to all who were celebrating the anniversary and expressed continued support for the program. In Denver, Colorado, HHS Secretary Tommy Thompson renewed his commitment to older adults at a kick-off celebration with the Assistant Secretary for Aging. The AoA published a history of the OAA Nutrition Program, highlighting significant legislative and implementation events. The Assistant Secretary for Aging and AoA personnel highlighted the anniversary at events held throughout the country by State Agencies on Aging, Area Agencies on Aging, and local nutrition service providers.

Nutrition Services Incentive Program (NSIP)

In 2002, the Bush Administration proposed and Congress passed the Consolidated Appropriations Resolution of 2003, Public Law 108-7, which amended the OAA to transfer the Nutrition Services Incentive Program (NSIP) as authorized in Section 311 of the OAA from the United States Department Of Agriculture (USDA) to AoA.

The AoA is now administering the NSIP including finalizing meal numbers, allocating funding, coordinating with USDA for commodity usage by some states and tribes, and finalizing payments to State Agencies on Aging and Tribal Organizations. The AoA provides cash assistance to State Agencies on Aging and Tribal Organizations under the NSIP, and is responsible for participation procedures, meal and financial reports, and compliance with the requirements of the OAA. The AoA contracts with USDA to administer the election, and ordering of commodities and the purchase and delivery of commodities to State Agencies on Aging and Tribal Organizations that use them. During the transition year, the AoA coordinated with the USDA, signed agreements with State Agencies on Aging and Tribal Organizations, provided guidance, and distributed funding.

Title VI Nutrition Services

Nutrition services are a major component of Tribal Title VI programs. Native elders receive nearly three million congregate and home-delivered meals annually. Most program sites provide hot congregate meals four to five times a week. Home-delivered meals are delivered five times a week for elders who generally are in poorer health, are more functionally impaired, get out of their homes less often, and need in-home supportive services. Most programs provide modified diets for diabetics, or others who might be on low-fat, low-cholesterol, and low-sodium diets. Several programs provide special nutrition services such as meals for homeless older persons an evening meal option for home-delivered meal participants, and weekend home-delivered meals.

Reach 2010 for the Elderly

In FY 2000, AoA entered into a Memorandum of Understanding with the Centers for Disease Control and Prevention (CDC) on an initiative to eliminate health disparities among racial and ethnic minority populations by mounting REACH 2010 for the Elderly. This major collaborative effort has the goal of improving the health status of older racial

and/or ethnic minority persons. Under this two phase, five year effort four projects were funded. Each project focuses on one major racial and ethnic minority group by establishing community coalitions and developing community action plans for reducing health care disparities in the areas of heart disease, diabetes, and immunization.

The Reach 2010 grantees are as follows:

- The Latino Education Project, Inc.
- Special Services for Groups, Inc.
- The Boston Public Health Commission
- The National Indian Council on Aging

Osteoporosis Initiative

In September 2002, AoA awarded $300,000 in grants to support the development of an osteoporosis awareness campaign aimed at post-menopausal women. Three organizations with extensive experience in the area of osteoporosis research and education received grants. These projects are assisting AoA in formulating an action plan to educate and raise awareness about osteoporosis among post-menopausal women. The projects will build on the experience of previous osteoporosis awareness efforts to develop an action plan that is innovative and offers effective outreach strategies.

Organizations receiving these grants include the following:

- The Foundation for Osteoporosis Research and Education
- The Osteoporosis Foundation
- The University of Maine

Medication Management

Medication management among older adults is a growing issue due to the increasing availability of improved and stronger medicines and because of the physiological changes that occur with aging. Congress authorized under the OAA appropriations process for the last two years an emphasis on medication management, screening, and education to prevent incorrect medication and adverse drug reactions. The Aging Network (in the aggregate) is ensuring that a minimum of $5 million is expended on medication management activities. One popular activity at senior centers is the brown bag program where seniors come into the senior center, bring all their medicines including over the counter medicines and have a pharmacist review the contents of their brown bag. This is a very popular program with the seniors.

Mental Health Initiatives

Companion Report to Surgeon General's Report on Mental Health

In January 2001, AoA released the *Companion Report to Surgeon General's Report on*

Mental Health, which expands on the discussion of older adults and mental health contained in the 1999 Surgeon General's report. The AoA report focuses on challenges in the delivery of mental health services to older Americans, and highlights a number of supportive services that can provide vital assistance to older adults with mental health problems and their families. The report sets forth the challenges that must be addressed in order to provide effective community-based care to older persons with mental illnesses. Identified needs include: expanding prevention and early intervention services; increasing the number of professionals and paraprofessionals trained in geriatric mental health; providing adequate financing for mental health services; enhancing collaboration among delivery systems; improving access to mental health care; educating the public about mental illness and mental health treatment; expanding research on mental health issues in older adults; addressing the mental health needs of special populations; and encouraging consumer involvement.

Mental Health and Aging Toolkit for the Aging Network

AoA collaborated with the Substance Abuse and Mental Health Services Administration and their contractor, the National Council on the Aging, to develop *Get Connected! Linking Older Adults with Medication, Alcohol and Mental Health Resource Toolkit.* These new materials will help providers in the Aging Services Network better understand and cope with issues related to medications, alcohol, and emotional problems among older people, and learn how best to provide the knowledge and support necessary to deal effectively with these issues. The kit includes fact sheets, a video, consumer brochures, training guides and curricula, promising practices manual, and a services resource guide. The toolkit was released in 2003.

SECTION III - Supporting Families in Their Efforts to Care for Their Loved Ones at Home and in the Community

Implementing the NFCSP

The National Family Caregiver Support Program (NFCSP), including the Native American Caregiver Support Program, was enacted as part of the Older Americans Act Amendments of 2000 (P.L. 106-501) signed into law on November 13, 2000 to provide supportive services for family caregivers. Since the enactment of the NFCSP, AoA and the national aging services network have demonstrated creativity in putting in place the five program components:

* Individualized information on available resources to support caregivers;
* Assistance to families in locating services from a variety of private and voluntary agencies;
* Caregiver counseling, training, and peer support to help them better cope with the emotional and physical stress of dealing with the disabling effects of a family member's chronic condition;
* Respite care provided in the home, at an adult day care center, or over a weekend in a nursing home or residential setting such as an assisted living facility; and

* Limited supplemental services to fill a service gap that cannot be filled in any other manner.

During calendar years 2001 and 2002, AoA initiated a number of activities to assist the national aging services network implement the NFCSP:

- Issued program instructions to help states and tribal organizations document how they are utilizing Title III-E and Title VI-C funds and ensure the effective use of these funds.
- Conducted a series of video and teleconference training sessions with every state agency on aging to provide guidance and technical assistance.
- Convened a conference in September 2001, *NFCSP: From Enactment to Action,* to highlight the new federal program. More than 700 representatives of the aging services network generated new ideas on family caregiving and systems development.
- Created a website devoted to the NFCSP. The website provides information to the national aging services network, researchers, policymakers and advocates on the characteristics and needs of family caregivers, future trends in family caregiving, offers program guidance in implementing the NFCSP.
- Commissioned a series of issue briefs from prominent researchers and leading national aging services network professionals on topics and issues related to family caregiving.
- Commissioned a *Resource Guide to the NFCSP* to provide implementation strategies and approaches that the aging network may consider in carrying out the new program.
- Created a NFCSP brochure that provides background information on the program, highlighting examples of innovative state caregiving programs. The brochure is available in Spanish, Russian and Mandarin Chinese languages.
- Developed *Caregiver Survival Tips*, a simple, ten-step approach to identifying areas where caregivers may need support. Information is provided on how to locate and access an array of supportive services. The tips have been made available in English, Spanish, Russian, and Chinese.

Supporting Promising Practices in Caregiving

In 2001 and 2002, AoA received funds to support research and demonstration projects under the NFCSP. The Older Americans Act provided authorization for three years of funding to support and foster the development and testing of new approaches to sustaining the efforts of families and other informal caregivers of older individuals. AoA funded 11 Projects of National Significance, 28 National Innovations Programs, and 9

Native American Caregiver Support Program grants. These competitive grants focus on systems development, service components, linkages to special populations and communities, field-initiated demonstrations to develop and test new approaches to support caregivers, and national projects that enhance the development of caregiver programs.

Caregivers Served by the NFCSP in 2002

The NFCSP, for a minimal cost, provides a variety of supports to the caregiver in order to help them care for their loved ones at home for as long as possible. By avoiding or delaying the need for more costly institutional care, caregiver services significantly reduce costs to other Federal and state programs. Consistent with AoA's commitment to focus on and measure results, the agency has begun to collect both administrative and sample survey data that speaks to program productivity. The following table, which includes updated data from states for FY 2002, illustrates how caregivers are being served through the NFCSP. The data indicate that states and communities are effectively reaching out to individuals who may benefit from this program, and are already providing a well-rounded mix of services to support caregivers.

NFCSP Component	Number of Caregivers Service
Information on available resources	3.8 million
Access to services	436,000
Counseling and training	180,000
Respite services	70,000
Supplemental Services	50,000

Administration on Aging convened an interdepartmental workgroup, the New Freedom Initiative Caregiver Support Workgroup, to identify opportunities for collaboration and coordination in the area of family caregiver support. The Caregiver Support Workgroup developed a *Compendium of HHS Caregiver Support Activities*. The Compendium, a first at HHS, catalogues existing efforts by HHS agencies to support family and informal caregivers.

Section IV - Ensuring the Rights of Older People and Prevent Their Abuse Neglect and Exploitation

Long-Term Care Ombudsman Program

Long-Term Care Ombudsmen are advocates for residents of long-term care facilities. They work to help resolve the problems confronting individuals in these facilities and to bring about changes at the local, state and national levels to improve care for all residents. As it is with other program activities, AoA focuses on the results produced through the Ombudsman Program through the analysis of program data provided by the states. The central message provided from the data provided by the states for FY 2001 is the significant increase in program productivity over a short period of time (since FY 1998). The data reflect that residents of long-term care facilities and their relatives and

those who work in those facilities rely far more significantly on the Ombudsman Program to help address and resolve issues and complaints than they did just three years earlier. The following items illustrate this observation.

- Ombudsmen provided 35% more consultations to individuals in FY 2001 than they provided in FY 1998.
- Ombudsmen provided 58% more consultations to facility staff in FY 2001 than they provided in FY 1998.
- Ombudsmen responded to 35% more complaints in FY 2001 than in FY 1998.
- Ombudsmen resolved 77% of the complaints they handled in FY 2001, compared to 71% in FY 1998.

Additional national data and other information provided by the states are included in the report *Long-Term Care Ombudsman Report FY* 2001, located in the appendix.

National Long Term Care Ombudsman Resource Center (NLTCORC)

AoA also funds a National Long Term Care Ombudsman Resource Center (NLTCORC) to provide support, technical assistance and training to ombudsmen programs around the country. The Center's objectives are to enhance the skills, knowledge and management capacity of the State programs to enable them to handle residents' complaints and represent resident interests (individual and systemic advocacy).

Nursing Home Quality Initiative

Department of Health and Human Services' Secretary Tommy Thompson, Centers for Medicare and Medicaid Services (CMS) Director Tom Scully and Assistant Secretary for Aging Josefina Carbonell and members of their staffs joined state and local ombudsmen in celebrating the 30th anniversary of the Ombudsman Program in the spring of 2002. The event served as the occasion to announce a partnership between CMS and AoA involving ombudsman participation in the CMS Nursing Home Quality Improvement Initiative to improve nursing homes by providing nursing home quality measure information to consumers using other strategies to improve care in selected homes. CMS funded ombudsman activities to support partnerships between the ombudsman programs and Quality Improvement Organizations (QIO) in the six pilot states (Colorado, Maryland, Ohio, Rhode Island, Florida, and Washington) and a training program and curriculum, which were made available to ombudsman programs and QIOs in all states.

National Center on Elder Abuse (NCEA)

AoA funds the NCEA, a national resource for elder rights, law enforcement and legal professionals, public policy leaders, researchers, and public. AoA worked to refocus the efforts of the Center to make sure that it promotes understanding, knowledge sharing, and action on elder abuse, neglect, and exploitation. The Center makes available news and resources, collaborates on research, provides consultation, education and training

identifies and provides information about promising practices and interventions, answers inquiries and requests for information, operates a listserve forum for professionals, and advises on program and policy development.

National Summit on Elder Abuse 2001 - A Call for Action

In December 2001, AoA supported the National Summit on Elder Abuse to explore ways to more effectively protect America's most vulnerable elders and to work toward a national consensus to action. The Summit brought together state and local public officials, national advocates, and experts from across the United States representing law enforcement, aging services networks, public health, adult protection, healthcare, mental health, criminal justice, and the research community.

Health Care Fraud and Abuse Control Program Activities

The AoA supports 54 Senior Medicare Patrol (SMP) Projects, community-based programs that utilize the skills and expertise of retired professionals in identifying and reporting waste, fraud and abuse in the Medicare and Medicaid programs. Approximately $77 million in documented savings have been recouped due to the efforts of the SMP Projects. This is an increase of 24.6% from calendar year 2000. It is not possible to document the sentinel effect of savings due to the heightened awareness of over one million beneficiaries SMPs have trained to track health care events, review their Medicare Summary Notices and Explanation of Medicare Benefit statements and report unresolved issues through the proper channels. Additional 2002 outcomes include:

- 9,000 new SMP volunteers were trained
- 400,000 beneficiaries were directly educated by the SMP volunteers

AoA also receives funding under the Health Insurance Portability and Accountability Act of 1996 to work in partnership with the Centers for Medicare & Medicaid Services, the Office of Inspector General, the Department of Justice, and others in a coordinated effort to combat and prevent waste, fraud, and abuse in Medicare and Medicaid. The AoA's efforts under this initiative have been to: 1) train professionals who provide services to older Americans about how to recognize and report potential instances of waste, fraud, and abuse; 2) support the work of four technical assistance resource centers which provide outreach activities to rural, isolated, or limited English-speaking individuals; 3) develop consumer education materials in English, Spanish, and Chinese; and 4) convene annual national and regional conferences which bring together government officials, health care professionals, aging service providers, and older Americans to share common strategies and practices.

National Legal Assistance Support Projects

AoA funds national level projects designed to build and strengthen a national system of legal assistance and to improve the quality and accessibility of the legal assistance provided to older people. AoA worked extensively with the five funded projects to

ensure that their efforts provided state and area agencies on aging and legal assistance providers with: (1) case consultations; (2) training; (3) provision of substantive legal advice and assistance; and (4) assistance in the design, implementation, and administration of legal assistance delivery and elder rights advocacy systems.

Legal Assistance Support Projects and areas of focus include:

- **The American Bar Association Commission on Law and Aging** provides elder law attorneys and aging network personnel with technical assistance on substantive legal issues.
- **The Center for Social Gerontology** helps states to improve their legal services delivery systems.
- **The AARP Foundation's National Training Project** provides in depth training and technical assistance in areas such as Medicare, nursing home law, advance directives, and strategic planning.
- **The National Consumer Law Center** improves legal assistance to older Americans whose finances and economic independence are threatened by scams and abuses in the marketplace.
- **The National Senior Citizens Law Center** provides in depth case consultations to senior legal services providers, and it conducts substantive training sessions at state and national conferences.

Enhancing Access to State Level Senior Legal Services

AoA funds senior legal services projects to strengthen and improve the delivery of critical legal services to hard-to-reach, frail, socially and economically disadvantaged, and otherwise at-risk older individuals. These projects offer legal staff and specially trained volunteers to provide advice on legal questions or problems, distribute self-help materials, and refer older individuals to legal aid offices, pro-bono, or reduced-fee private attorneys who specialize in elder rights protection.

The senior legal services program allows AoA to test innovative approaches to expanding access to legal services such as establishing self-help offices staffed by non-legal volunteers and interactive website assistance at community service agencies and libraries. Current projects are focusing on a myriad of innovations including: providing extensive outreach to Hispanic, African American, and rural elderly clients; utilizing staff-supervised non-attorney volunteers to provide legal services; building community coalitions; establishing senior legal help lines; and utilizing law students to provide brief services for bankruptcy and debt protections.

Pension Information and Counseling Program

AoA funds nine pension counseling demonstration projects which serve sixteen states:

Alabama, Arizona, California, Connecticut, Illinois, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New York, Ohio, Rhode Island, Vermont, and Wisconsin. The pension counseling demonstration projects supported by AoA since 1993 have assisted over 10,000 older Americans individually with pension problems and have recouped over $40 million in pension claims. Each of the pension counseling projects brings its own unique model to the program. Some projects operate with full-time lawyers, others rely on highly trained volunteers to provide assistance. The projects provide a range of services, from answering pension questions to providing legal assistance to obtain promised pension benefits.

Pension Counseling and Information Projects serve their clients with four basic levels of service.

- Provides basic information that includes quick answers to telephone inquiries and requests for fact sheets.
- Assists retirement plan participants in collecting benefit and work history information in order to understand the rules of their specific plan, or to aid in proving service.
- Provides detailed document review and advice, to ensure that individuals understand their rights and benefits under their particular plan and advising clients on how to enforce those rights and receive their benefits.
- Assistance through any administrative claim and review procedure upon determining that a client has been wrongfully or mistakenly denied a particular benefit.

Technical Assistance Provided to Pension Projects

Because of the complexity of the law and the many different retirement systems, there is a need for ongoing training and technical assistance. This is provided by the Program's Technical Assistance Project (TAP). The training takes the form of an annual national training seminar in Washington, DC each year for all project directors and key staff, and regular on-site training at each project location. Each event is tailored to the specific needs of project staff involved. Technical assistance takes the form of day-to-day telephone and e-mail legal backup and advice on difficult issues. TAP also works with the projects on issues related to project administration, such as data collection and reporting, client education and outreach, as well as grant writing and fundraising strategies. TAP identifies and shares best practices information across the projects, increasing overall quality and efficiency of services provided, and getting newly funded projects quickly and effectively trained. The Pension Rights Center in Washington, DC operates the TAP project.

Issues Address by the Program

The issues faced by the clients of the counseling projects run the full gamut of pension law issues. The complexity of these issues is increased dramatically by the fact that the Program covers all pension and retirement savings plans across the country, whether they

are sponsored by a private company governed by the private pension law, ERISA; a federal plan such as FERS, CSRS, Railroad Retirement or the Military retirement system; or a state, county or city retirement plan.

Regardless of the type of employer sponsoring the plan, the most frequent pension issues brought to the attention of the projects are those faced by widows and divorced spouses in being denied survivor's benefits or failure to obtain an appropriate court order in divorce proceedings. Other problems faced by project clients include:

- failures to properly credit service under the plan, resulting in questions concerning vesting and accrual of benefits;
- improper application of pension formulas, resulting in incorrect pension calculations;
- questions relating to all varieties of distributions such as lump sums versus annuities, mandatory cash outs, and delayed payouts from 401(k) plans; and
- the inability of individuals to locate pensions from companies that have relocated or gone out of business, otherwise knows as "lost pensions."

Regardless of the type of issue involved, the experience of the counseling projects has made it clear that workers, retirees and their family members facing these difficult issues need the assistance of a trusted and competent service provider.

Section V- International Activities

As the federal focal point for older Americans and their caregivers, the AoA plays a vital role in information exchange on aging issues with other countries, and in collaborating with international organizations to enhance aging programs and policies worldwide. The AoA responds to requests for information from international organizations such as the United Nations, foreign governments, and agencies. It hosts international scholars, officials and practitioners who come to the U. S. to learn firsthand about America's response to population aging. In 2001 and 2002, AoA staff briefed numerous foreign visitors from governmental ministries, universities, local municipalities and aging organizations.

Among them was a two day visit by the Director of the Mexican National Institute on Older Persons (Instituto Nacional de Adult en Plenitude or INACEN) in the Ministry of Social Development. Visits were arranged with Centers for Medicare and Medicaid, AARP, and with AoA staff to discuss a number of matters of joint interest, e.g. adult immunization, national health card, micro enterprise activities, our "On The Move campaign." AoA sent five boxes of deaccessioned books to the INACEN library.

The AoA participates in a number of collaborative efforts with other countries and with international organizations, such as the World Health Organization, to enhance aging programs and policies worldwide.

The Aging Core Group of the Health Working Group, U.S.- Mexico Binational Commission. The Commission promotes exchanges at the Cabinet level on a wide range of issues critical to U.S.-Mexico relations. The Aging Core Group is one of six areas of collaboration between the U.S. Department of Health and Human Services and the Mexican Ministry of Health. The Assistant Secretary for Aging leads the U.S. side of the Core Group. In 2001 and 2002 we continued to share our models and experiences in these areas:

- Home and community - based care services for the elderly and their caregivers;
- Breast, colorectal and prostate cancer, including information from AEn Acción@, the National Hispanic Leadership Initiative on Cancer, and the National Hispanic Colorectal Cancer Outreach and Education Program;
- Community-based programs supporting Alzheimer Disease patients and their caregivers; and
- Health promotion and protection for the elderly, focusing on diabetes, high blood pressure, and nutrition and exercise programs.

- **The 2nd World Assembly on Ageing 2002.** The Assistant Secretary for Aging, Josefina G. Carbonell led the U.S. delegation to the Second World Assembly on Ageing in Madrid, Spain, April 8-12, 2002 (remarks at http://www.aoa.gov/prof/international/aoa_related/aoa_related_remarks.asp. The delegation consisted of officials from the U.S. Department of Health and Human Services, Ambassador Sichan Siv and other State Department officials, and the following private sector delegates:
    - Richard Browdie, Secretary of Aging,Pennsylvania Department of Aging
    - Esther Canja, President, AARP
    - Monsignor Charles Fahey, Program Officer, Milbank Memorial Fund
    - Clayton S. Fong, President, National Asian Pacific Center on Aging
    - Merl C. Hokenstad, Jr., Professor, Case Western Reserve University
    - James L. Martin, President, 60 Plus Association
    - Louise Myers, Executive Director, IONA Senior Services
    - Lupe Wissell, U.S. Senate, Special Committee on Aging
    - William De La Peña, MD, Medical Director, De La

During the Assembly, UN member states discussed and finalized the International Plan of Action on Ageing (the "Plan") 2002, a revision of the 1982 International Plan of Action developed by the First World Assembly on Ageing http://www.un.org/esa/socdev/ageing/waa/. AoA helped to develop the Plan by coordinating the Federal government's input to the Plan and by serving on the U.S. delegation to the UN in its deliberations on the Plan. The final text contains language that is fully consistent with U.S. policy. The Plan will serve as a blueprint for governments worldwide in addressing critical issues facing rapid global population aging, including health, development, migration, environment and intergenerational concerns.

Berlin Ministerial Conference on Ageing, 11-13 September 2002

As a follow up to the World Assembly on Ageing, the UN Economic Commission for Europe (UNECE), in cooperation with the Germany Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, http://www.mica2002.de/, held a Regional Ministerial Conference on Ageing in Berlin, Germany. UNECE member states adopted a Regional Implementation Strategy and a Ministerial Declaration.

AoA coordinated Federal government input and helped to develop the Strategy and Declaration. AoA staff also served on the U.S. delegation to the conference and have coordinated follow up activities.

Teleconferences with Bombay and Calcutta, India.
AoA was invited to participate in two teleconferences organized by the State Department. Senior AoA staff discussed Older American Act programs with gerontologists in Bombay and Calcutta.

Pan American Health Organization (PAHO).
AoA continued to collaborate with PAHO on aging-related issues. In addition to preparing significant input/review of aging documents for the annual PAHO meeting, AoA served on a PAHO advisory committee to develop and publish the publication "ProMotion: A Way of Life for Older Adults: A Regional Guide for Promoting Physical Activity." This publication, available in both Spanish and English, was distributed not only to Latin American and Caribbean countries but also to the U.S. Aging Network.

Section VI – Promoting Effective and Responsive Management

Performance Measurement

AoA and the aging services network continue to increase their capacity to measure performance results and to improve those results. AoA now utilizes two major sources of data to measure program performance for its state-administered service programs: 1) the state program report submitted by state agencies under the National Aging Program Information System, and 2) AoA's national performance outcome measures surveys.

Detailed information from both of these sources are presented in the following appendices: 1) *The 2002-2003 National Survey of Older Americans Act Participants (summary report)*, and 2) *2001 State Program Report.* Data from the state program report demonstrate that:

- state and area agencies on aging effectively target services to the most vulnerable elderly populations, including the poor, disabled, minorities, and elders in rural areas;
- states and communities leverage funding from non-AoA sources at a level that is twice the funding that AoA provides; and
- efficiency, as measured by individuals served per million dollars of AoA funding, has improved in each of the last three years.

Data from AoA's national outcomes surveys demonstrate not only that elder individuals and their caregivers are satisfied with the services they receive, but also that they find the services useful and effective in helping elder individuals remain in the community.

The Assistant Secretary on Aging is committed to demonstrating the accountability and worth of Older Americans Act programs through performance measurement. As a result, AoA initiatives and efforts to improve performance measures and to improve performance results will continue to be a high priority of the agency.

The following summarizes significant outcome characteristics of Older Americans Act programs, as reflected by the data that AoA uses to measure program performance:

- AoA's Home and Community-Based Service Programs have shown steady improvement in service efficiency over the last three years. The number of clients served per million dollars of AoA funding for 1999, 2000 and 2001 are: 6,293; 6,373; and 6,425.

- 86% of family caregivers reported in 2002 that Older Americans Act Services help them care for elders longer than they could have without the services.

- 38% of elderly individuals who receive Older Americans Act transportation services rely on those services for virtually all of their transportation needs.

- 30% of elderly individuals who receive home-delivered meals are nursing-home eligible (3 or more ADLs), but are successfully residing at home.

- Eight State Units on Aging improved targeting to poor individuals by more than 10 percent between FY 2000 and 2001.

- 61% of elderly individuals receiving OAA homemaker services reported they had annual income of $10,000 or less.

- 79% of elderly individuals receiving OAA home-delivered meals are at high nutritional risk.

Workforce Planning Initiative

A mid-term assessment of AoA's workforce planning initiative (2001-2005) has shown that AoA has made significant progress. AoA has made great improvements in its workforce, meeting the goals of the agency, the department and the current administration.

AoA identified the four most critical workforce issues facing the agency in 2001:

- Improve the supervisory ratio,
- Balance the grade structure,
- Implement continuity/succession planning, and
- Expand training opportunities.

The goals of the agency Workforce Plan 2001 – 2005 directly address these issues.

In FY 2002, the Assistant Secretary completely restructured the organization by reducing the number of layers to a maximum of three, decreasing the number of organizational units from seven to four and consolidating all administrative management functions at the Agency level, thereby accomplishing its restructuring and administrative consolidation goals, and achieving average grade and employee/supervisory ratio goals outlined in the workforce plan and the Government Performance and Results Act (GPRA) plan objectives.

AoA has expanded its training opportunities reflecting a shift in its role from an emphasis on mandated programs to the development of integrated strategies to meet the demands of our aging society. Staff have been retrained to assume new responsibilities. Staff have also increased their knowledge of information technology resources that can assist them to provide better customer service.

The Workforce Plan calls for AoA to now direct its energies toward continuity and succession planning. For the final two years (2004-2005) AoA will expand its team leader positions, and build on the identification of unique skills sets critical to the agency's mission. AoA will develop a rotational assignment program to provide staff with exposure to a variety of AoA functions.

AoA is pleased with its progress in meeting the Workforce Plan goals and objectives. We have reorganized the agency to be more efficient and more responsive to staff and to our constituencies and stakeholders. We have increased the use of current technologies to reach more people concerned and involved in the aging issues that face the nation today. By streamlining and refocusing the Agency on its strategic mission, AoA is better able to serve the Aging Network and older Americans.

Section VII - Program Direction

	FY 2000	FY 2001	FY 2002
Supportive Services & Centers	$310,020,000	$325,027,000	$356,981,000
National Family Caregiver Support	---	124,981,000	141,492,000
Congregate Meals	374,336,000	378,356,000	390,000,000
Home-Delivered Meals	146,970,000	151,978,000	176,500,000
Preventive Health Services	16,120,000	21,120,000	21,123,000
State and Local Innovations/ Projects of National Significance	31,156,000	37,664,000	40,636,000
Grants to Native Americans	18,457,000	23,457,000	25,722,000
Vulnerable Older Americans	13,179,000	14,181,000	17,681,000
Alzheimer's Disease	5,968,000	8,962,000	11,483,000
Program Administration	16,458,000	17,216,000	18,053,000
TOTAL, Budget Authority	$932,664,000	$1,102,942,000	$1,199,671,000

APPENDICES

APPENDIX I: The 2002-2003 National Survey of Older Americans Act Participants (summary report)

APPENDIX II: Long-Term Care Ombudsman Annual Report

APPENDIX III: Report on Native American Programs

APPENDIX IV: 2001 State Program Report

Highlights from the *Pilot Study: First National Survey of Older Americans Act Title III Service Recipients* – Paper No. 1

This paper highlights early findings of the *Pilot Study: First National Survey of Older Americans Act Title III Service Recipients.* This study, which demonstrates the Administration on Aging's (AoA) commitment to performance measurement, shows that services provided by the National Aging Services Network 1) are highly rated by recipients; 2) are effectively targeted to vulnerable populations and individuals who need the service; and 3) provide assistance to individuals and caregivers which is instrumental in allowing older persons to maintain their independence and avoid premature nursing home placement.

Background

The Agency: AoA's mission is to promote the dignity and independence of older people, and to help society prepare for an aging population. Created in 1965 with the enactment of the Older Americans Act (OAA), AoA is part of a federal, state, tribal and local partnership called the National Aging Services Network. This network consists of 56 State Units on Aging (SUAs); 655 Area Agencies on Aging (AAAs); 244 Tribal and Native organizations; two organizations that serve Native Hawaiians; 29,000 local service providers; and over 500,000 volunteers. The network serves about 7.5 million older persons under Title III of the OAA; in addition over 400,000 caregivers each year receive services under the National Family Caregiver Support Program.

In support of this mission, AoA has established five strategic goals for the agency:

1. Increase the number of older people who have access to an integrated array of health and home and community-based services.
2. Increase the number of older people who stay active and healthy.
3. Increase the number of families who receive help in their efforts to care for their loved ones at home and in the community.
4. Increase the number of older people who benefit from programs that protect their rights and prevent elder abuse, neglect and exploitation.
5. Strengthen the effectiveness and responsiveness of AoA's management practices.

The AoA program activities support these strategic goals.

The Program: The legislative intent of the Community-Based Services program (Title III of the Older Americans Act) is to make community-based services available to elders who are at risk of losing their independence. It is intended further that States and communities participate actively in funding community-based services and develop the capacity in communities across the States to support the home and community-based service needs of elderly individuals, particularly the poor, minorities and those who live in rural areas where access to services may be limited. Under Title III, SUAs are allocated funds for state and community programs based on formulas that reflect the number of older residents in their state. The AoA, other Federal, state, local and private source funds are used by SUAs, AAAs and service providers to coordinate and to provide services for elderly individuals.

The Community-Based Services program covers the majority of the resources, services and activities of the AoA and the National Aging Services Network. The program provides **"access"**

services, such as information and assistance, outreach, and transportation; **"community"** services, which include nutrition services, including meals, senior-center activities, adult day care, pension counseling, and health promotion and physical activity programs; **"in-home"** services, including home-delivered meals, chore, home maintenance assistance, home-health, and personal care; and **"caregiver"** support, such as respite services and information and assistance to caregivers for the coordination of health and social services.

Performance Measurement: In response to the ever increasing emphasis on effective performance measurement as required by the Government Performance and Results Act (GPRA) and the Office of Management and Budget's Program Assessment Rating Tool (PART), and Section 202(f) of the Older Americans Act, AoA is engaged in an on-going demonstration project, the Performance Outcomes Measures Project (POMP), with representatives of SUAs and AAAs. The purpose of POMP is to develop tools that SUAs and AAAs can use to measure performance for representative services funded under Title III.

The OAA establishes service programs for the elderly and assures that state and local agencies are given wide latitude to design services tailored to the needs of their regions and communities. One challenge for the Federal government is to devise a means to improve the performance of the program nationally while preserving and promoting the diversity of program design and administration. With POMP, AoA is providing states and area agencies with the tools to identify elements of service quality, so that they can make service systems more efficient and effective at the local level.

Through a collaborative process initiated in 1999, AoA and representatives from SUAs and AAAs across the country have crafted survey instruments to measure elements of service quality and consumer service assessment. POMP is demonstrating the ability of state and area agencies on aging to apply statistically sound sampling techniques to obtain numeric measures of program performance.

The survey instruments – along with various tools necessary for implementation – are available at www.gpra.net for use by states and area agencies. Some agencies have raised the level of awareness about their programs, and the level of funding by presenting the results of their performance measurement surveys to elected officials, philanthropic organizations and other sources of financial support. Others have made program improvements, using the survey results to identify areas in need of attention.

The National Pilot Survey: After the POMP instruments had demonstrated utility at the state and local levels, the national pilot survey was undertaken to determine the feasibility of employing the POMP performance measurement methodology at the national level. Secondary purposes, assuming the feasibility, were to 1) develop annual performance targets and begin to measure progress toward long-term performance targets; 2) develop preliminary national benchmarks for use by states and AAAs; 3) develop plans for a full-scale national performance measurement study in FY 2005 with sample sizes large enough to allow for analysis by subgroup and geographical region; 4) explore the feasibility of substituting survey reporting for some of the program reporting requirements; 5) plan the next phase of POMP; and 6) assess, at the Federal level, the practical utility of the various performance measurement instruments and, within the instruments, of the various data elements. Ultimately, performance measurement information is incorporated into AoA planning and budgeting.

National Pilot Survey Methodology

The national pilot survey was conducted from November 2002 to February 2003 by Westat, Inc., AoA's survey contractor. The national pilot survey questionnaires, which evolved from POMP, include several representative Title III service domains, including:

- Nutrition Programs (including congregate and home-delivered)
- Transportation Services
- Information and Referral/Assistance Services
- Homemaker Services (community-based long term care)
- Caregivers

In addition, survey instruments were designed to document client characteristics, including

- Physical Functioning
- Demographics
- Emotional Well-Being
- Social Functioning

For the first national pilot survey, Westat, Inc. developed a two-stage sample design. For the first stage, a sampling frame of the universe of AAAs was utilized and a random sample of 150 area agencies was selected (132 agreed to participate). For the second stage, a random sample of four recipients per area agency per service domain was selected.

Survey Results

Results from the national pilot survey demonstrated that the performance measurement protocols developed under the POMP demonstration project could be replicated at the national level. The results of the pilot enabled AoA to incorporate new performance outcome measures into its planning and budget processes. In addition, preliminary national benchmarks are now available so states and AAAs can compare their performance to national norms.

Overall, consumer assessment of Title III service quality was very high. A brief summary of key findings for each service domain is provided below.

Transportation Services: It is national policy to help older Americans remain independent and participate fully in community life. Affordable mobility providing access to community services is key to supporting this national policy. Affordable mobility is necessary for many older adults to access health care and other personal services, retail, business, recreation and social engagements. Unfortunately, older adults are at high risk of losing their mobility as a result of functional impairments and the lack of access to transportation services.

Through its Supportive Services and Senior Centers Program under Title III of the OAA, the AoA provides formula funding to the SUAs for a wide array of supportive services. Approximately $360 million is appropriated annually for this program. SUAs award funds to AAAs, most use a portion of these funds to help meet the transportation needs of older persons. In FY 2001, more than 42 million one-way trips were provided to older persons by 2,900 local transportation providers at a Federal cost of approximately $72.5 million. In addition, approximately $129 million was leveraged by SUAs and AAAs to further meet the transportation needs of older persons.

A total of 397 recipients of OAA transportation services responded to the pilot survey. A brief summary of key findings follows:

1. **Transportation services are highly rated.**
   - 99% of respondents rated services good to excellent.
   - 91% of respondents reported that the drivers were always polite.
   - 97% of respondents would recommend the service to a friend.

2. **Transportation services are targeted to vulnerable individuals.**
   - 80% of respondents reporting income had annual income under $20,000; 52% had annual income under $10,000.
   - 61% of respondents live alone.
   - 65% of respondents are 75 or older.

3. **Transportation services are provided to individuals needing services.**
   - 38% of respondents rely on OAA transportation services for all or nearly all their local transportation. An additional 25% rely on these services for at least half of their local transportation.
   - 80% of respondents are either unable to drive or have no vehicle available.

4. **Transportation services are both reliable and accessible.**
   - 92% of respondents reported they usually or always arrived at their destination on time.
   - 96% of respondents reported the vehicle comes to their home; of these 50% reported that the driver comes to the door.
   - 96% of respondents reported the drivers always or usually pick them up when they are supposed to.

5. **Transportation services help individuals get to important destinations, assisting them in maintaining their independence.**
   - 82% of respondents reported they always got the rides they needed; an additional 12% said they usually got the needed rides.
   - 70% of respondents reported using the service to get to a doctor or health care provider; 43% of respondents report using the service to go shopping.

Information and Referral/ Assistance Services: The Older Americans Act (OAA) requires that all older persons and their caregivers have reasonably convenient, direct access to information and referral services which are available to help them identify, understand and effectively use home and community-based programs and services. The Information and Referral/Assistance (I&R/A) network serves as the gateway to OAA programs and services at the state and local levels. There are approximately 2,100 I&R/A service providers for the aging across the country. These I&R/A providers assisted over 13 million people in 2001 at a Federal cost of $40.7 million, with an additional 2 million served through proactive outreach according to State Program Report (SPR) data. In addition, approximately $48.1 million was leveraged by SUAs and AAAs for I&R/A services.

A total of 337 recipients of OAA I&R/A services responded to the pilot survey. A brief summary of key findings follows:

1. **I&R/A services are highly rated.**
   - 93% of respondents were satisfied with the way the call was handled (58% very satisfied; 25% satisfied; 9% somewhat satisfied)
   - 89% of respondents would recommend the service to a friend.

2. **I&R/A services serve as a gateway to OAA programs for vulnerable individuals and their caretakers.**
   - 58% of respondents reported the purpose of their call was to obtain help or services for themselves; an additional 42% reported they were calling seeking help or assistance for a relative or friend.
   - 70% of the respondents wanted to obtain services.
   - 76% of the callers surveyed reported that this was the first time they used the service.
   - 65% of survey respondents reported family income under $15,000.

3. **I&R/A services are accessible.**
   - 98% of callers surveyed reported they got through to the service after three or fewer attempts.
   - 95% of respondents said their call was answered within five rings.
   - 85% of respondents reported their call was answered by a person rather than voice mail.

4. **Persons providing I&R/A services are communicating effectively.**
   - 97% of the survey respondents reported that the person they spoke to understood what they were saying.
   - 94% of respondents reported that the person they talked to explained things so that the caller could understand them.

5. **Information provided through I&R/A services is useful to the caller.**
   - 88% of respondents reported that information received was helpful in resolving their issues (63% said the information was definitely helpful and 25% thought the information was helpful).

Homemaker Services: Older Americans Act services, especially those provided to vulnerable older individuals in their homes, are intended to help the elderly maintain their independence and remain in the community. Homemaker services, which assist elderly individuals in a variety of ways in the home, are central to this fundamental objective of the Act. With these services, disabled elderly individuals receive help with tasks such as preparing meals, shopping for personal items, doing light housework, and managing money. Homemaker services are another service component under the Supportive Services and Senior Centers Program under Title III of the Older Americans Act. In FY 2001, more than 10 million hours of homemaker support were provided to older persons at a cost to AoA of approximately $22 million. Reflecting the recognition of the aging network of the importance of homemaker services to the elderly, another $80 million, almost four times the amount provided by AoA, was leveraged by States and AAAs to provide homemaker services to older persons.

A total of 407 recipients of OAA homemaker services responded to the pilot survey. A brief summary of key findings follows:

1. **Homemaker services are effectively targeted to vulnerable populations.**
   - 69% of respondents reported they are living alone.
   - 85% of respondents reported annual incomes under $15,000.
   - 72% of respondents were age 75 and over.

2. **Homemaker services are successfully targeted to the socially isolated.**
   - 47% of the respondents to this survey reported they would like to be doing more with respect to their social activities. In contrast, results from the *National Health Interview Survey's Second Supplement on Aging* for the total elderly population, defined as age 70 or over, reported that 24% of respondents would like to be doing more.

3. **Homemaker services provided are high quality in the perception of the service recipient.**
   - 87% of respondents reported that their service provider is thorough.
   - 88% of respondents reported that their service provider does things the way they should be done.
   - 92% of respondents reported that their service provider listens to instructions.

4. **Homemaker services provide assistance needed by individuals to maintain their independence.**
   - 84% of respondents reported difficulty in doing housework; 99% of these people reported they needed assistance.

5. **Recipients of homemaker service are more impaired and frail than the entire 60+ population, suggesting that these OAA services contribute to maintaining individuals in their homes.**
   - 43% of respondents reported 3 or more ADL limitations, which is an indicator of high risk for loss of independence and institutionalization.
   - 65% of respondents reported needing assistance with one or more ADLs. In contrast, the Census Bureau's *Survey of Income and Program Participation* shows that the need for assistance with one or more ADLs in the total age 60+ population is 6%. Personal assistance needs for recipients of OAA homemaker services are ten times higher than in the elderly population overall.

- 90% of respondents reported needing assistance with one or more IADLs. In contrast, the *Survey of Income and Program Participation* shows that only 14% of the total age 60+ population needed such assistance.

Home Delivered Nutrition Program: Adequate nutrition is essential for healthy aging, the prevention or delay of chronic diseases and disease-related disabilities, the treatment and management of chronic diseases, and quality of life. The reduction of risk for chronic disease such as heart disease, certain types of cancer, diabetes, stroke, and osteoporosis, the leading causes of death and disability among Americans, is related to good diets and improved nutritional habits. Good diets can also reduce major risk factors for chronic disease such as obesity, high blood pressure, and high blood cholesterol. Millions of older Americans lack access to the quantity and quality of food necessary to maintain health and decrease the risk of disability. The Older Americans Act requires that Nutrition Programs provide meals and related nutrition services that promote health and help manage chronic disease. Older Americans participating in the Home Delivered Nutrition Program are a vulnerable population that are older, more frail, have higher nutritional risk, have more functional impairments that result from nutrition related diseases and conditions, are lower income and may have more limited access to food. For these individuals, the meal provided by the OAA Nutrition Program may be their primary source of food. This essential service within home and community based services provides an important social link with the community and helps delay institutionalization. In FY 2001, approximately 930,000 older persons received home delivered meals. Over 143 million meals were provided at a cost to AoA of approximately $173 million. Reflecting the recognition of the aging network of the importance of home delivered meals to the elderly, another $423 million was leveraged by SUAs and AAAs to provide home delivered meals to older persons.

A total of 736 recipients of OAA home delivered meals responded to the pilot survey. A brief summary of key findings follows:

1. **Home Delivered Nutrition services are effectively targeted to vulnerable populations.**
   - 59% of respondents reported they are living alone.
   - 84% of respondents reported annual family incomes under $15,000.
   - 69% of respondents were age 75 and over; the mean age is 78.5.
   - 79% of respondents reported difficulty with at least one Activity of Daily Living (ADL) – such activities as eating, dressing or walking.

2. **Home Delivered Nutrition services are successfully targeted to the socially isolated.**
   - 47% of the respondents to this survey reported they would like to be doing more with respect to their social activities. Results from the *National Health Interview Survey's Second Supplement on Aging* for the total elderly population, defined as age 70 or over, reported that 24% of respondents would like to be doing more.

3. **Home Delivered Nutrition services provided are high quality and reliable in the perception of the service recipient.**
   - 94% of respondents reported that they liked the meal.
   - 91% of respondents reported that meals always or almost always arrive when expected.

4. **Home Delivered meals are provided to individuals who need them.**
   - 73% of respondents were at high nutritional risk; 25% were at moderate risk.

- 62% of respondents reported that home delivered meals provided one half or more of their daily food intake.
- 25% of respondents reported they did not always have enough money or food stamps to buy food.

5. **Home Delivered meal recipients exhibit much greater levels of impairment or frailty than the entire 60+ population, suggesting that these OAA services contribute to maintaining individuals in their homes.**
   - 30% of respondents reported 3 or more ADL limitations, which is an indicator of high risk for loss of independence and institutionalization.
   - 52% of respondents reported needing assistance with one or more ADLs, the Census Bureau's *Survey of Income and Program Participation* shows that the need for assistance with one or more ADLs in the total 60+ population is 6%. Personal assistance needs for recipients of OAA home delivered meals are more than 8 times higher than in the elderly population overall.
   - 74% of respondents reported needing assistance with one or more IADLs, the *Survey of Income and Program Participation* shows that 14% of the total 60+ population needed such assistance.

Congregate Nutrition Program: Millions of older Americans lack access to the quantity and quality of food necessary to maintain health and decrease the risk of disability. The Older Americans Act requires that Nutrition Programs provide meals and related nutrition services that promote health and help manage chronic disease. Older Americans participating in the Congregate Nutrition Program have the opportunity to improve their health status and reduce their risk of disability through lifestyle behaviors emphasized within the Congregate Nutrition Program, through healthy meals, and culturally appropriate nutrition education and physical activity programs. In addition, participation in the program provides active social engagement and linkages to volunteer activities that are essential for maintaining mental and physical health and well-being. Older Americans participating in the Congregate Nutrition Program are a vulnerable population that are older, have a higher nutritional risk, are lower income, and may have more limited access to food. For these individuals, the meal provided by the OAA Nutrition Program may be their primary source of food for the day. This essential health promotion/disease prevention program helps delay the onset of more serious diseases and conditions that lead to the need for more in-home services. In FY 2001, nearly 1.75 million older Americans received congregate meals. Over 112 million meals were provided at a cost to AoA of approximately $259 million. Reflecting the recognition of the aging network of the importance of congregate meals for the elderly, another $330 million was leveraged by SUAs and AAAs to provide congregate meals to older persons

A total of 473 recipients of OAA congregate meals responded to the pilot survey. A brief summary of key findings follows:

1. **Congregate nutrition services are effectively targeted to vulnerable populations.**
   - 64% of respondents are age 75 or older.
   - 65% of respondents reported annual family incomes under $15,000.
   - 56% of respondents are living alone.

2. **The Congregate Nutrition Program is highly rated by respondents.**
   - 92% of respondents reported they were satisfied with the taste of the food.

- 97% of respondents reported they were satisfied with the food temperature.
- 99% of respondents believe the meal site is a safe place.

3. **The Congregate Nutrition Program provides opportunities for socialization.**
   - 96% of respondents reported they like to visit with friends at the site.
   - 73% of respondents like to participate in activities at the meal site.
   - 60% of respondents report their social opportunities have increased since they started receiving congregate nutrition services.

4. **Congregate meals are provided to people who need them.**
   - 43% of respondents are at high nutritional risk; 48% are at moderate nutritional risk.
   - 58% of respondents reported that congregate meals provided one half or more of their daily food intake.
   - 11% of respondents reported they do not always have enough money or food stamps to buy food.

Caregivers: The role of caregivers in helping elderly individuals to maintain their independence in the community is well documented. Estimates indicate that nearly one out of every four U.S. households (23 percent or 22.4 million) contain at least one caregiver for a relative or friend at least 50 years old.[1] Recognizing the value and needs of family caregivers, the U.S. Congress added the National Family Caregiver Support Program (NFCSP) to the OAA in 2000, and states and communities across the nation have begun to establish programs on their behalf over the last two years. Data from SUAs indicate that they have reached out to some 3.8 million individuals to inform them about the new caregiver program, and that at least 436,000 caregivers received some form of direct support under this program in 2002.

Recognizing that the program initiation was too recent to expect to identify and interview caregivers about the effects of the new program, AoA nevertheless wanted to obtain the views of caregivers about the OAA services provided to elderly family and friends, and to identify their service needs. A total of 417 caregivers of elderly OAA clients responded to the pilot caregiver survey. A brief summary of key findings follows:

1. **Caregiving duties are undertaken primarily by female family members, and many are elderly themselves.**
   - 95% of respondents were relatives of an elderly OAA client.
   - 70% of respondents are women, primarily daughters.
   - 46% of respondents are aged 60 and over themselves.
   - 27% of respondents reported they have a condition which limits the care they can provide as caregivers.

2. **These caregivers perform a wide variety of activities for the elders they serve.**
   - 85% of respondents take them to the doctor and shopping.
   - 78% of respondents prepare meals and do the laundry.
   - 70% of respondents keep track of bills and finances.
   - 56% of respondents help with medicine and bandages.

[1] National Alliance for Caregiving and the American Association for Retired Persons (1997).

3. **OAA services to the elderly are valued by and help caregivers.**
   - 93% of respondents are satisfied with the services provided to the elderly they care for, and 65% are very satisfied.
   - 69% of respondents said that OAA services made them a better caregiver.
   - 86% of respondents said that OAA services allow them to care longer for the elderly than they could without the services; 48% said the OAA services definitely produced that result; 38% "think" the services produced that result.

4. **Caregivers have significant needs of their own.**
   - 76% of respondents said they wanted one place to call for help.
   - 64% of respondents said they needed help in dealing with service organizations.
   - 52% of respondents said they needed a stipend, tax break or other financial help.
   - 49% of respondents said they needed help with housekeeping; significant percentages also said they needed help with transportation (38%), personal care (33%) and other activities.

Summary of Key Findings

The *Pilot Study: First National Survey of Older Americans Act Title III Service Recipients* demonstrates that services provided by the National Aging Services Network 1) are highly rated by recipients; 2) are effectively targeted to vulnerable populations and to individuals who need the service; and 3) provide assistance to individuals and caregivers which is instrumental in allowing older persons to maintain their independence and avoid premature nursing home placement.

Native American Programs Report

The Older Americans Act (OAA) Title VI, Grants to Native Americans programs, administered by the Administration on Aging (AoA), provide nutrition and supportive services, as well as family caregiver support services, that help elders remain healthy and independent. Grant awards are made directly to Tribal organizations representing American Indians and Alaska Natives and organizations representing Native Hawaiians. In FY 2001, $23, 457,000 was awarded to 233 organizations representing nearly 300 Tribes under Title VI, Part A and to two organizations serving Native Hawaiians under Title VI, Part B. In FY 2002, funding increased to $25,729,000 and eight additional grants were awarded under Title VI, Part A.

Greater numbers of American Indian, Alaska Native and Native Hawaiians are living longer and many are living well into their eighties and nineties. This welcome trend is resulting in increased numbers of elders receiving Title VI services. As shown in Table 1, nearly 112,000 elders received meals and/or supportive services in FY 2001. This number increased 34 percent, to just over 150,000, in FY 2002.

Table 1: Unduplicated counts of elders receiving services.

	FY 2001	FY 2002
Congregate Meals	38,229	50,387
Home-Delivered Meals	21,235	32,926
Supportive Services	51,902	67,121

Research shows that individuals of any age can improve their health status and reduce the risk of disease and disability if they practice healthy behaviors. Title VI Senior Centers provide a safe environment for elders to have nutritious meals with their friends, have their blood pressure and blood sugar checked, learn about healthy behaviors and take part in various exercise programs.

Nutrition services, including congregate meals, home-delivered meals, nutrition screening and nutrition education, are among the core services provided by Title VI programs. As shown in Table 2, three million meals were served to elders in either a congregate setting or in their homes in

both FY 2001 and FY 2002. In addition to a hot meal, the congregate nutrition program provides an opportunity for elders to socialize and take part in a wide variety of activities, including cultural activities and physical activity programs. The home-delivered meals program plays an important role in managing diseases and disabilities for homebound elders. For elders living alone, home-delivered meals provides social contact to reduce the risk of depression and isolation and improve dietary intakes. In addition, home-delivered meals provide an essential service to many caregivers by helping them maintain their own health and well-being.

As shown in Table 2, over 2 million supportive services were provided in FY 2001 and FY 2002. Supportive services include information, assistance, transportation and other access services that help elders in accessing necessary services. Supportive services also include various in-home services, such as personal care services, homemaker services, chore services and friendly visits. These services enable elders to remain in their homes and communities.

Table 2: Total number of services provided.

	FY 2001	FY 2002
Congregate Meals	1,317,101	1,430,539
Home Delivered Meals	1,686,338	1,869,886
Access Services, including Transportation	1,539,212	1,578,981
In-Home Services	770,209	883,103
All Others	470,132	493,276

The Native American Family Caregiver Support Program, Title VI, Part C, was created with the 2000 amendments to the OAA and was implemented in FY 2001. Only Tribes and Native Hawaiian Organizations receiving a Title VI, Part A or Part B grant are eligible for a Part C grant. In FY 2001, $5,000,000 was awarded to 119 grantees for support services to family caregivers. In FY 2002, $5,500,000 was awarded to 186 grantees.

Most grantees are in the development stages of their Native American Family Caregiver Support Programs. Since few programs for caregiver support are available within the Tribe, most programs are building the infrastructure to support such a program. During the first two years of the

program, at least 4,230 caregivers received one or more caregiver support services. Respite service is provided by most programs, including respite for grandparents. Nearly two-thirds of the programs are providing support groups or individual counseling for caregivers. Over half the programs are providing caregiver training.

The AoA is working closely with Tribes and the organizations that provide support to them, including the two AoA funded National Resource Centers on Native American Aging, to better identify and meet the needs of elders. Issues affecting Native American elders, include elder abuse, food safety, home safety, home and community based long-term care, caregiver issues and Title VI program issues. Some of these efforts include:

- Needs Assessment: The University of North Dakota's National Resource Center on Native American Aging worked with AoA to design and complete a needs assessment for elders. Information collected includes general health status, indicators of chronic diseases, indicators of activity limitations, diet and exercise information and indicators of social supports. Nearly 100 Tribes have participated in the needs assessment. The Resource Center is working with the Tribes to use local level data for purposes ranging from grant applications to planning for long-term care services.

- Professional Training: The University of Colorado's National Resource Center on Native American Aging developed continuing education modules for professionals working with Native American elders. These modules are: Diabetes Mellitus (Type II) in American Indian/Alaska Native Elders: Cultural Aspects of Care; and Cancer Among Elder Native Americans. These modules are on available on their web site.

- Native Hawaiian Health: Alu Like, a program grantee, is collaborating with the Native Hawaiian Health Care system to help Native Hawaiian elders maintain or improve their health. Because of this collaboration, elders are offered routine health screenings and appropriate follow-up services. Program staff reinforce healthy lifestyles through group physical activities and discussions about nutrition.

- Long-Term Care in Indian Country Roundtable: AoA, Indian Health Service, and the National Indian Council on Aging co-sponsored a roundtable on Long-Term Care in Indian Country to develop a better understanding of what long-term care looks like in Indian

country today and what direction the Tribes would like to take in the future.

- Tribal Listening Sessions: AoA convened Tribal Listening Sessions in both FY 2001 and 2002 to hear from Tribal leaders, Title VI directors, elders and Tribal organizations about issues affecting the lives of Native American elders, including health, long-term care and regulations that may be necessary because of the reauthorization of the OAA.

ADMINISTRATION ON AGING STATE PROGRAM REPORT

A Summary of State and Community Programs under Title III of the Older Americans Act of 1965, as amended

Federal Fiscal Year 2000

U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201

November 2003

PREFACE

This report describes the characteristics of state and community programs on aging under Title III of the Older Americans Act (OAA) for Federal Fiscal Year 2000. The contents of the report are based on data provided by the State Units on Aging (SUAs) that administer the program throughout the U.S. For Federal programs, the analysis of timely, accurate, and comparable data is of growing importance in the context of the Government Performance and Results Act (GPRA); and related state and local initiatives that seek to link continued funding to the demonstrated benefits and outcomes require quality data as well. The data presented and analyzed in this report provide the Administration on Aging (AoA) and the states with a solid basis for demonstrating that OAA programs produce results for elder Americans. AoA uses these data extensively in the agency's GPRA plans and reports, and many state and local governments are employing such data under similar systems of accountability to document results and justify funding.

Through the *State Program Report* (SPR), all State Units on Aging (SUAs), including the District of Columbia, Puerto Rico and Guam, in conjunction with local Area Agencies on Aging (AAAs), submit data on their clients and services to the Administration on Aging (AoA). In presenting the data provided to AoA, this document is organized according to several key program areas, including client characteristics, the range of services they receive, program staffing, and costs. Of particular note in this report is a presentation of findings regarding the disability status of elderly clients. In the late 1990s, AoA and the state and community entities that administer the program initiated processes to provide data on the functional status of clients who need assistance in performing personal care and home management activities, such as bathing, dressing, meal preparation, and housekeeping. For 2000, this report includes a compilation of this information from 39 states and Guam and, over time, the coverage will expand to all SUAs. The benefit of the analysis of this functional status information is to focus attention on the extent to which home- and community-based services are assisting and supporting a vulnerable population at risk for loss of independence.

This report answers basic questions about the OAA network of state and community programs on aging, including: 1) who participates in OAA programs; 2) what services do participants receive; 3) how much do the services cost; 4) what additional funds have SUAs and AAAs raised through leveraging efforts; 5) what are the characteristics of OAA clients; and 6) how many staff support OAA programs, and what are their responsibilities?

SUMMARY HIGHLIGHTS

Each year, AoA awards OAA funds to every state based primarily on the size of the elderly population, age 60 and over. The states, in turn, develop and administer a diverse set of home and community-based services through a designated State Unit on Aging (SUA), local Area Agencies on Aging (AAAs), and an array of community service providers. Several states with relatively small populations combine the SUA and AAA functions into a single agency.

The following highlights present summary information on the clients, services, expenditures, and staffing of OAA programs.

Clients

- A total of 7.0 million persons age 60 and over received services through state and community programs on aging supported by the OAA.
- Over 30 percent of these program participants had incomes below the poverty level, a rate about three times higher than the total population in this age group.
- Fifty-one percent of the minority clients were poor, a rate about four times higher than the minority elderly population overall.[1]
- Consistent with OAA targeting criteria, nearly 1/3 of the program participants lived in rural areas, compared to less than one-quarter for the total population age 60+.

Services

- Through OAA transportation programs, older persons received 40.3 million trips to medical services, grocery stores, and other community locations.
- Clients with limitations in such basic life activities as bathing, dressing, cooking, and cleaning received 11.3 million hours of personal care and 9.8 million hours of homemaker services through SUA and AAA home-care programs.
- Over 1.7 million persons received more than 116 million meals in congregate settings, and 954,504 persons received 143.8 million meals delivered to their homes.
- More than 458,000 persons received over 3.2 million hours of case management services, providing these persons with individual needs assessments and service delivery arrangements to support independent living.

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[1] Note: Excludes Puerto Rico

- A total of 6,598 senior centers received OAA Title III funding, and most of these served as community focal points, bringing together a wide range of programs and services in a central location.

Budgets, Staffing, Advocacy, and Program Development

- SUAs and AAAs raised nearly $1.4 billion through leveraging efforts for use in conjunction with the $719 million in AoA dollars they spent in 2000.

- Beyond these funds, many SUAs also administered other, large programs for the elderly through separate initiatives, such as Medicaid Waiver home-care services or other programs financed entirely with state appropriations.

- There were 4,063 full-time equivalent paid staff members working in SUAs, about one-third (33.8%) of whom were supported with OAA Title III funding. Financial support for nearly two-thirds of SUA staffing came from the effective leveraging efforts of these state agencies.

- Another 21,951 full-time equivalent paid staff members worked at the local level in AAAs, nearly 45 percent of whom were supported by Title III. Funding for over half of AAA staffing came from the effective leveraging efforts of these local agencies. The AAA staff were supported by 17,342 volunteers in the provision of information and other assistance for the elderly.

- OAA Title III Supportive Services comprising the highest level of expenditures in 2000 were:

  - Transportation $65.3 million
  - Information and assistance $38.8 million
  - Homemaker $23.0 million
  - Legal services $20.7 million
  - Case management $18.9 million

- OAA Title III nutrition services expenditures in 2000 were:

  - $248.5 million for congregate meals, and
  - $164.6 million for home-delivered meals.

- Beyond funding a range of programs for the aging, SUAs and AAAs also enhanced the well-being of older persons by:

  - initiating policies, legislation, and other action to help protect the rights of the elderly, enhance access to community-based care and other benefits, and increase the level and scope of available services,

- conducting studies on the status and needs of the elderly, building partnerships with other state and local agencies, and coordinating the planning and delivery of services for the aging, and

- promoting public understanding of the elderly's service needs and providing information on programs that serve older persons.

1. INTRODUCTION

1.1 The Older Americans Act

The Older Americans Act (OAA) of 1965, as amended, has fostered the creation of a national network of State and Area Agencies on Aging, Indian tribal organizations, and service providers to address the needs of our nation's senior citizens. Through the development efforts of this network on aging a nationwide infrastructure of home and community-based services has emerged.

The OAA network has two primary responsibilities. First, it delivers a range of services to the elderly, including home care, nutrition, transportation, information and assistance, and advocacy on behalf of individual older persons. Second, to augment the limited funding under the OAA, this network also functions in an important policy, planning, and advocacy role vis-à-vis other public and private programs and funding, to enhance the well-being and independence of the elderly. The SUAs and AAAs, with their provider organizations, not only use their OAA funding for services, but also leverage other federal, state, and local public and private funds to support programs on aging.

For more than 35 years, OAA programs have heightened public awareness of the needs of older individuals and served as a catalyst for the development of an array of services that help older persons remain independent and participate in community life.

1.2 Who Participates in Older Americans Act Programs?

In 2000, the network of SUAs and AAAs provided services to a total of 6,992,784 persons age 60 and older. This represented approximately 15 percent of the 46 million persons in this age group. Consistent with the targeting requirements of the OAA, the network placed considerable emphasis on services to persons with the greatest social and economic need. This included elderly in poverty, those living in rural areas where access to services may be limited, and members of racial and ethnic minority groups, especially those who are poor. A summary of this information appears in Table A.

Table A. Characteristics of Persons Served under Title III of the Older Americans Act, FY 2000*		
Characteristics	Persons Served	Total U.S. Population Age 60+
Total	6,992,784	46,382,901
Poverty	30.3%	9.9%
Rural	32.9%	22.4%
Minority	19.1%	18.6%

*Includes 50 States, DC, Puerto Rico

Of the total population served under SUA and AAA OAA Title III programs, 30.3 percent were poor, compared to 9.9 percent for the total 60+ population in 2000. In addition, nearly one-third of the service recipients (32.9%) lived in rural areas, compared to 22.4 percent for the total elderly population 60 years of age and above. Among the OAA Title III service recipients, 19.1 percent were members of racial and ethnic minority groups. By way of comparison, 18.6 percent of all persons age 60 and over were minority group members in 2000.

Table B shows that over half (53%) of the minority clients were African American, 29.6 percent were of Hispanic origin, 4.2 percent were American Indian or Alaskan Native, and 13.6 percent were Asian American or Pacific Islander. Within this minority group cohort, 55 percent were poor, a poverty rate nearly three times higher than the minority elderly population overall (19 percent). This demonstrates a substantial degree of targeting of services to low income minority elderly.

Table B. Characteristics of Minority Clients Served under Title III of the Older Americans Act, FY 2000*		
Characteristics	Minority Clients Served	Total Minority Population 60+
Total Minority	1,341,195	8,627,418
African American (non-Hispanic)	53.0%	48.8%
Hispanic	29.6%	34.1%
American Indian/Alaskan Native	4.2%	2.6%
Asian American/Pacific Islander	13.6%	14.5%
Minority in Poverty	55.0%	19.0%

*Includes 50 states, DC, Puerto Rico

1.3 What Services Do Program Participants Receive?

The Administration on Aging collects data on 14 specific services, plus an *other* category, consistent with the information from the SPR and the definitions in Appendix D. The *other* services category includes many services that are either unique to particular states or constitute relatively small expenditures. These include friendly visiting and telephone reassurance, emergency response systems, or programs for groups of elderly, such as wellness and health screening events at community locations.

The 14 community-based services include the following:

- Personal care
- Homemaker
- Chore
- Home-delivered meals
- Adult day care/health
- Case management
- Congregate meals
- Nutrition counseling
- Assisted transportation
- Transportation
- Legal assistance
- Nutritional education
- Information and assistance
- Outreach
- Other services

The 14 services cover a broad spectrum of care. They facilitate access to programs by assessing client needs and arranging for the delivery of services from a range of available providers. In addition, these services include personal care and home management assistance to support a vulnerable elderly population at home or in other community settings as alternatives to institutional placement. They also include meals, health and nutrition education, and other programs in congregate settings. Older persons participate in many of these community services as part of senior center programs that bring together essential supports in a convenient central location. At the same time, they provide opportunities for social interaction to combat isolation and promote emotional well-being.

1.4 How Much Do the Services Cost?

Title III of the OAA gives SUAs and AAAs considerable discretion in funding a range of services tailored to individual state and community needs and circumstances. While some programs are required by OAA legislation and regulations, such as Title III C nutrition services, the flexibility under Title III B allows wide latitude on which programs to support. For these reasons, the specific services SUAs report and the expenditure of OAA funds among them vary considerably.

OAA appropriations allocate funds separately for supportive services, under Title III B, and for congregate and home-delivered nutrition services, under Title III C 1 and 2. Within these two broad areas, some nationwide patterns have emerged in the specific services with the largest expenditure of OAA funds.

OAA Title IIIB Supportive Services with the highest expenditure levels for 2000 were:

- Transportation $65.3 million
- Information and assistance $38.8 million
- Homemaker $23.0 million
- Legal services $20.7 million
- Case management $18.9 million

OAA Title IIIC nutrition services expenditures in 2000 were:

- Congregate meals $248.5 million
- Home-delivered meals $164.6 million

Table C presents OAA Title III expenditures for each of the 14 and other services, showing the relative emphasis among them. In addition, to provide as complete a picture as possible, the table also shows the additional funding SUAs, AAAs, and local service providers have leveraged for use in conjunction with the OAA allocations to fund their services. In many cases, the OAA Title III allocation is small when compared to the additional funding SUAs, AAAs, and local service providers raise and use for services. For this reason, it is useful to

analyze OAA Title III service expenditure patterns in the context of the additional resources available.

The amount of these additional funds varies considerably by service, according to state and local policies and legislation.

Table C. OAA Title III Expenditures By Service, FY 2000*

Service	OAA Title III Federal Expenditures		Additional Expenditures		Total Expenditures for Each Service	
	$	%	$	%	$	%
Personal Care	$12,397,058	1.7%	$118,501,581	8.6%	$130,898,639	6.3%
Homemaker	$23,040,884	3.2%	$57,917,066	4.2%	$80,957,950	3.9%
Chore	$5,470,261	0.8%	$12,388,235	0.9%	$17,858,496	0.9%
Home-Delivered Meals	$164,638,849	22.9%	$367,274,096	26.8%	$531,912,945	25.5%
Adult Day Care/Health	$9,934,770	1.4%	$44,180,356	3.2%	$54,115,126	2.6%
Case Management	$18,949,325	2.6%	$61,059,325	4.5%	$80,008,650	3.8%
Congregate Meals	$248,518,121	34.6%	$313,850,484	22.9%	$562,368,605	26.9%
Nutrition Counseling	$1,381,182	0.2%	$788,624	0.1%	$2,169,806	0.1%
Assisted Transportation	$3,400,690	0.5%	$11,144,707	0.8%	$14,545,397	0.7%
Transportation	$65,328,427	9.1%	$96,249,253	7.0%	$161,577,680	7.7%
Legal Assistance	$20,662,216	2.9%	$19,722,599	1.4%	$40,384,815	1.9%
Nutrition Education	$3,476,533	0.5%	$2,415,612	0.2%	$5,892,145	0.3%
Information and Assistance	$38,793,889	5.4%	$50,454,903	3.7%	$89,248,792	4.3%
Outreach	$11,345,763	1.6%	$12,764,774	0.9%	$24,110,537	1.2%
Other Services	$91,350,298	12.7%	$202,164,298	14.7%	$293,514,596	14.0%
Total	$230,957,126	32.1%	$383,771,439	28.0%	$614,728,565	29.4%

*Includes 50 States, DC, Puerto Rico

The availability (or absence) of additional resources may influence the extent to which states choose to support a particular service with OAA Title III funds. Some SUAs and AAAs use OAA funds to fill gaps by supplementing the other large but often narrowly-focused Federal and state programs they also administer. For example, SUAs may operate Medicaid Waiver home care programs that actually exceed the total level of OAA funding. Unlike Title III services, however, these programs often have very strict income eligibility requirements and cover only specific services.

By comparing the OAA Title III expenditures with the additional outlays, we can see the relative balance, and potential interaction, between these two categories of financial support. For example, Table C shows that states spent $12.4 million in OAA Title III funds for personal care in 2000, but expenditures for personal care from additional sources totaled nearly

ten times that amount, or $118.7 million. Clearly, the availability of funds such as Medicaid Waiver funds and appropriations from state legislatures, which make up these additional SUA expenditures for personal care, allowed states to allocate their OAA Title III funds for other needed services.

Nutrition services also constituted a major use of the additional funds raised by the network on aging, but with a much heavier emphasis on home-delivered meals than was the case for OAA Title IIIC allocations. Also, while congregate and home-delivered meals programs comprised the first and second highest expenditure categories for OAA Title III funds, the order was reversed for the additional funding, showing the emphasis on in-home services that these additional funds often allowed.

Individual states often differed substantially from one another in how they allocated their total funds to various services however. Table D shows this variation by dividing the 52 SUAs into four equal groups of 13, or quartiles, and displaying the corresponding percentage of total expenditures, by service, for each of the four groups, from low to high. For example, while personal care constituted an average of 6.3 percent of the total service expenditures, as shown in Table C, we see from Table D that a full three-quarters of the SUAs actually spent less than this level. The first quartile spent between 0 and 0.7 percent of their total budget on personal care. The second spent between 0.7 and 2.1 percent, and the third spent between 1.5 and 3.4 percent. The fourth quartile of 13 SUAs, however, spent between 3.4 and 29.7 percent of their total funds for personal care.

Obviously, the nationwide expenditure patterns for personal care are influenced by a few states in the top quartile that allocate relatively large amounts of funding for this service. This pattern also exists for adult day care/health and assisted transportation where a relatively few states fund these services with either OAA Title III or additional resources.

Conversely, given the OAA legislative mandate for nutrition services, congregate meals expenditures as a percent of total outlays do not vary to the same degree. The average from Table C is about 30 percent, and Table D shows that half the SUAs report expenditures that are close to this figure—between 21.2 and 35.8 percent of the total. There is a core set of services that states fund on a relatively consistent basis, using both their OAA Title III and additional allocations of funds. These services include transportation and information and assistance, as well as the OAA-required legal services and congregate and home-delivered nutrition programs.

Table D. SUA Service Expenditures as a Percentage of Total Costs, In Quartiles, FY 2000*					
	1st	2nd	3rd	4th	
Service	Minimum	25th Percentile	Median	75th Percentile	Maximum
Personal Care	0.0%	0.2%	1.5%	3.4%	29.7%
Homemaker	0.0%	1.2%	3.2%	6.6%	26.7%
Chore	0.0%	0.0%	0.4%	0.9%	11.6%
Home-Delivered Meals	7.5%	20.8%	26.2%	29.9%	47.4%
Adult Day Care/Health	0.0%	0.3%	1.7%	4.2%	12.7%
Case Management	0.0%	0.3%	2.2%	6.6%	26.4%
Congregate Meals	9.0%	21.2%	29.8%	35.7%	51.2%
Nutrition Counseling	0.0%	0.0%	0.0%	0.1%	0.7%
Assisted Transportation	0.0%	0.0%	0.1%	0.5%	7.6%
Transportation	0.0%	5.3%	7.9%	11.0%	21.7%
Legal Assistance	0.0%	1.0%	1.5%	2.3%	9.7%
Nutrition Education	0.0%	0.0%	0.1%	0.3%	2.9%
Information & Assistance	0.0%	1.5%	2.9%	4.8%	14.8%
Outreach	0.0%	0.4%	1.1%	2.0%	13.9%
Other	0.0%	5.3%	8.8%	14.1%	34.4%

*Includes 50 states, DC, Puerto Rico

Some services, such as homemaker and case management, fall into a middle group where one-quarter to one-half of the states fund them at a level approaching the national average, using either OAA Title III or additional funding sources.

1.5 What Additional Funds Have SUAs and AAAs Raised Through Leveraging Efforts?

The presence of the additional funding is an indication of the considerable service systems development, advocacy, and leveraging functions that SUAs and AAAs perform, in conjunction with their local service providers. Table E shows that, overall, OAA Title III funds represented just over one-third (34.4%) of the total in 2000. This means that, for every dollar of OAA Title III funds, SUAs reported leveraging nearly two additional dollars to support a core set of programs and services for older persons. Forty-five states reported that over half of their total budget came from these additional sources, while only nine states said the majority of funds came from OAA Title III. Consistent with the original vision of the OAA, these data show that

OAA programs have been able to tap considerable additional financial resources to support services for the aging.

In reality, this leveraging goes far beyond the dollar amounts that appear in this report. It is important to note that, in addition to these expenditures, there are many programs serving the elderly that SUAs administer separately, as well as others which serve the elderly but do not flow through either the SUA or AAA. These additional programs often include Social Services Block Grants (SSBG), Medicaid Waivers providing in-home services, and state-funded, community-based, long-term care services that do not involve the use of OAA funds and, therefore, do not appear in Tables C or E.

In addition to the fundraising work of SUAs, leveraging has occurred at the AAA level as well. For example, according to a 1996 survey conducted by the National Association of Area Agencies on Aging, AAAs supplemented their SUA allocations with many other sources, including SSBGs they receive from other state agencies, county and city funds, foundations, and private donations to support their home and community-based services.[2,3]

Despite the availability of these additional resources, certain essential services are very reliant on OAA Title III funding. Table E illustrates this by ranking the OAA Title III expenditures as a percentage of the total. For example, Table E shows that over half of legal assistance expenditures, and more than 40 percent of outreach, information and assistance, and transportation services outlays came from Title III, compared to the other funds SUAs reported. This shows the very important role OAA Title III plays as part of a comprehensive and coordinated system of services for the elderly, supported by both the OAA and the additional financial resources.

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[2] 1996 N4A Survey in conjunction with the National Association of State Units on Aging (NASUA)

[3] 1994 State Source Book "Infrastructure of Home and Community-Based Services for the Functionally Impaired Elderly"

Table E. OAA Title III Funds as a Percentage of Total Resources, FY 2000*			
Service	OAA Title III Federal Expenditures	Total Service Expenditures	Title III as a Percent of Total Expenditures
Nutrition Counseling	$1,381,182	$2,169,806	63.7%
Nutrition Education	$3,476,533	$5,892,145	59.0%
Legal Assistance	$20,662,216	$40,384,815	51.2%
Outreach	$11,345,763	$24,110,537	47.1%
Congregate Meals	$248,518,121	$562,368,605	44.2%
Information & Assistance	$38,793,889	$89,248,792	43.5%
Transportation	$65,328,427	$161,577,680	40.4%
Other Services	$91,350,298	$293,514,596	31.1%
Home-Delivered Meals	$164,638,849	$531,912,945	31.0%
Chore	$5,470,261	$17,858,496	30.6%
Homemaker	$23,040,884	$80,957,950	28.5%
Case Management	$18,949,325	$80,008,650	23.7%
Assisted Transportation	$3,400,690	$14,545,397	23.4%
Adult Day Care/Health	$9,934,770	$54,115,126	18.4%
Personal Care	$12,397,058	$130,898,639	9.5%
Total	$718,688,266	$2,089,564,179	34.4%

*Includes 50 states, DC, Puerto Rico

1.6 What Are the Characteristics of OAA Clients and Services?

1.6.1 Numbers of Persons Receiving OAA Services

Table F shows the number of persons receiving specific services supported by OAA programs in 2000. This table presents the nine services for which SUA provided information per the SPR requirements. The remaining five services do not require individual client registration, and only dollar expenditures and units of service information are reported (see Tables C and J).

Consistent with the expenditure patterns in Table C, congregate and home-delivered meals served the largest numbers of persons. Over 1.7 million persons participated in the congregate meals program, and more than 950,000 received home-delivered meals. Nearly 456,000 persons received case management to assess their needs and arrange for necessary services. Almost 160,000 persons received homemaker services, and over 113,000 received

personal care to help them live independently in the community. Persons often received more than one service, and not all clients participated in every program.

Table F. Estimated Unduplicated Count of Persons Served Under Title III of the OAA, FY 2000

Service	Number of Persons Served
Personal Care	113,892
Homemaker	159,764
Chore	56,351
Home-Delivered Meals	953,038
Adult Day Care	35,255
Case Management	456,530
Congregate Meals	1,743,292
Nutrition Counseling	34,926
Assisted Transportation	76,999

1.6.2 Functional Status of OAA Title III Clients

In 2000, SUAs began reporting information on the need among clients for assistance in performing such basic life activities as bathing, dressing, meals preparation, shopping for household items, and taking care of one's home. This information is indicative of a risk for institutionalization and a need for assistance in performing personal care and home management activities to remain independent in the community. States are reporting this information, separately, for each of six services that are specifically designed to support the independent living needs of this vulnerable elderly population:

- Personal Care
- Homemaker
- Chore
- Home-Delivered Meals
- Adult Day Care/Health
- Case Management

Most SUAs have begun reporting this new information, and over time all of them will provide functional status data on the clients they serve. For this report, functional limitation data

from 40 states were available for analysis and presentation, as specified in table footnotes. These data provide some interesting findings but are representative only of the 40 states and cannot be generalized to the nation as a whole. This information is collected in terms of two standard measures widely used in gerontological research: needing assistance from another person to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

1.6.2.1 Activities of Daily Living (ADLs)

The ADL personal assistance needs in Table G refer to care of the person, where there was an inability to perform one or more of the following six activities without assistance, standby assistance, supervision, or cues:

- Eating
- Dressing
- Bathing
- Toileting (getting to or using the toilet)
- Transferring in and out of bed or chair
- Walking.

For those services specifically designed to support the ADL limitations (Adult Day Care/Health, Case Management, and Personal Care), between 58 and 89 percent of clients served need assistance with one or more ADL's.

According to the U.S. Census Bureau's 1994-95 Survey of Income and Program Participation (SIPP), we know that the need for personal assistance with ADLs in the total 60+ population is relatively low, at 6.0 percent, but these rates rise substantially with age.[4] For example, persons 60 to 64 years of age have a rate of 2.7 percent, and for persons 65 to 79 years of age, the rate is 4.8 percent. For persons age 80 and above, the rate is considerably higher at 15.3 percent.

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[4] McNeil, John. "Americans with Disabilities: 1997 or 2000 data," *Current Population Reports*, P70-61 and unpublished tabulations by the author. U.S. Bureau of the Census, Washington, DC. August 2000.

Table G. Percentage of Clients Who Need Personal Assistance with Activities of Daily Living (ADLs), FY 2000			
Services	Age Group	Number of Clients served	Percent Who Need Assistance with 1 + ADLs
Personal Care	60-64	4,709	78.2%
	65-74	19,529	82.5%
	75-84	32,142	86.9%
	85+	25,260	88.8%
	Total	81,370	85.9%
Homemaker	60-64	5,010	62.0%
	65-74	22,866	62.5%
	75-84	45,268	64.3%
	85+	35,704	68.7%
	Total	108,848	65.2%
Chore	60-64	1,882	40.0%
	65-74	8,634	45.2%
	75-84	15,827	46.9%
	85+	10,465	52.2%
	Total	36,808	47.7%
Home-Delivered Meals	60-64	40,771	52.5%
	65-74	132,459	59.7%
	75-84	224,557	60.7%
	85+	168,761	61.1%
	Total	566,548	60.0%
Adult Day Care	60-64	1,041	58.1%
	65-74	3,544	65.1%
	75-84	7,524	70.9%
	85+	5,965	73.3%
	Total	18,074	69.8%
Case Management	60-64	23,363	64.0%
	65-74	53,983	65.9%
	75-84	92,604	69.0%
	85+	64,006	69.3%
	Total	233,956	67.9%
Selected States: AL, AR, AZ, CO, CT, FL, GA, HI, IA, ID, IL, IN, LA, MA, ME, MI, MN, MO, MT, NC, ND, NE, NH, NM, NV, OH, OR PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WV, WY and Guam			
Source: Administration on Aging, DHHS, 2000			
Missing data are excluded in calculating percentages			

Compared to these frailty rates for the total elderly population, we see that the network on aging reported considerably higher levels and targeted these six services to persons who required the assistance of others in performing these basic life activities. About 48 percent of clients who received chore services needed assistance with one or more ADLs, and 86 percent who received personal care needed assistance with one or more ADLs.

Another interesting finding is that, unlike the elderly population as a whole, the ADL limitation rates among service recipients remained relatively constant across the age cohorts. At the same time, Table G shows that the majority of clients receiving these services were in the advanced age groups of 75 and above. This suggests that, for the younger clientele, the network on aging is effectively screening clients for ADL limitations, and for its clientele, overall, the network is focusing on the age cohort most likely to need assistance in performing ADLs.

1.6.2.2 Instrumental Activities of Daily Living (IADLs)

The IADL measures concern care of the home where there is an inability to perform one or more of the following eight activities without personal or standby assistance, supervision or cues:

- Preparing meals
- Shopping for personal items
- Medication management
- Managing money
- Telephone usage
- Heavy housework
- Light housework
- Transportation

Table H presents the percent of clients (from 40 states) who need personal assistance to perform one or more of the eight IADLs, for the six listed services. Consistent with the home management focus of many of these services and the increased numbers of elderly who have limitations, we see very large percentages of clients from these 40 states that need

Table H. Percentage of Clients Who Need Personal Assistance with Instrumental Activities of Daily Living (IADLs), FY 2000			
Services	Age Group	Number of Clients served	Percent Who Need Assistance with 1 + IADLs
Personal Care	60-64	4,709	94.8%
	65-74	19,529	95.3%
	75-84	32,142	95.1%
	85+	25,260	94.6%
	Total	81,370	95.0%
Homemaker	60-64	5,010	89.8%
	65-74	22,866	90.3%
	75-84	45,268	90.3%
	85+	35,704	91.2%
	Total	108,848	90.6%
Chore	60-64	1,882	71.9%
	65-74	8,634	77.3%
	75-84	15,827	80.1%
	85+	10,465	82.7%
	Total	36,808	79.8%
Home-Delivered Meals	60-64	40,771	77.3%
	65-74	132,459	82.4%
	75-84	224,557	83.9%
	85+	168,761	84.3%
	Total	566,548	83.2%
Adult Day Care	60-64	1,041	78.4%
	65-74	3,544	83.4%
	75-84	7,524	87.5%
	85+	5,965	88.5%
	Total	18,074	86.5%
Case Management	60-64	23,363	79.3%
	65-74	53,983	87.0%
	75-84	92,604	89.6%
	85+	64,006	90.7%
	Total	233,956	88.4%
Selected States: AL, AR, AZ, CO, CT, FL, GA, HI, IA, ID, IL, IN, LA, MA, ME, MI, MN, MO, MT, NC, ND, NE, NH, NM, NV, OH, OR PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WV, WY and Guam			
Source: Administration on Aging, DHHS, 2000			
Missing data are excluded in calculating percentages			

IADL assistance. These averaged from a low of 79.8 percent for chore services, to a high of 95.0 percent for personal care. Variations in these rates across the age spectrum are most significant for those clients receiving chore, adult day care/health and case management services. In these instances, the rate of clients age 85 and above receiving these services is a full 10 percent higher than the rate of clients age 60 to 64 receiving the same services. Similar to the patterns in Table G, the majority of clients who need personal assistance with IADLs are in the advanced age groups of 75 years and over.

The ADL and IADL scales are hierarchical. That is, ADLs cover the most basic of personal care activities, which are primarily physical in nature, and are essential for independent living. Given the high level of severity that ADL assistance needs encompass, relatively few elderly in the general population report having them. IADLs, however, cover a more complex array of activities necessary for home management and require both physical and cognitive capabilities. For this reason, there are more persons who need assistance with IADLs than ADLs. This hierarchical pattern means that those who need help performing ADLs also often need assistance with IADLs as well.

According to the 1994-95 U.S. Census Survey of Income and Program Participation (SIPP), 13.5 percent of the population 60+ needed personal assistance with one or more IADLs, ranging from a low of 6.2 percent for the 60 to 64 age cohort to a high of 34.1 percent for the population age 80 and above. Compared to these rates among the elderly, overall, the network is serving persons with a need for an IADL assistance to a far greater extent than their prevalence in the general household population.

1.6.3 Gender and Living Alone Status of Clients

Beyond data on functional limitation status and age, the new SPR information from the 40 states on *registered* clients also includes gender and living alone status. Table I shows that for six of the nine services, approximately half of the clients live alone. For adult day care/health, however, about one-third live alone, consistent with the respite focus of this service for many clients. Adult day care/health is often provided for very frail older persons living with a family caregiver who works outside the home during the day and needs supervision services while he or she is away.

Table I. Living Alone Status and Gender of Clients, by Services, FY 2000				
			Gender	
Services	Number Served	Living alone	Male	Female
Personal Care	81,370	46.3%	25.8%	74.2%
Homemaker	108,848	64.2%	21.2%	78.8%
Chore	36,808	55.1%	22.0%	78.0%
Home Delivered Meals	566,548	47.3%	31.3%	68.7%
Adult Day Care	18,074	20.3%	31.9%	68.1%
Case Management	233,956	43.6%	30.5%	69.5%
Congregate Meals	1,104,577	40.8%	32.9%	32.9%
Nutrition Counseling	9,672	42.3%	30.3%	69.7%
Assisted Transportation	20,721	45.5%	22.3%	77.7%
Selected States: AL, AR, AZ, CO, CT, FL, GA, HI, IA, ID, IL, IN, LA, MA, ME, MI, MN, MO, MT, NC, ND, NE, NH, NM, NV, OH, OR PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WV, WY and Guam				
Source: Administration on Aging, DHHS, 2000				
Missing data are excluded in calculating percentages				

With the exception of congregate meals and nutrition counseling, the *registered* services in this table focus on clients with severe functional limitations, and these are often associated with persons of advanced age. We saw from Tables G and H that the vast majority of clients were 75 years old and above, an age group that is predominantly women, with high rates of poverty and frailty. For example, among the total population age 75+, over 63 percent were female, and women made up an even larger percentage of the at-risk, elderly population. For example, according to the Census Bureau, nearly 70 percent of the elderly population below poverty level in the United States is female, and 58 percent of those women have a disability. Additionally, over 80 percent of the elderly population below poverty level who live alone are females. (Census 2000, SF3 data.) Consistent with this demographic pattern in the population as a whole, Table I shows that between two-thirds and three-quarters of the service recipients were female.

1.6.4 Levels of Service

Thus far we have looked at the numbers and characteristics of persons receiving services funded under OAA Title III. Table J shows the amount of each service that OAA programs provide in terms of standard unit measures.

Table J. Units Of Service Delivered, FY 2000*		
Service	Unit Measure	Total Units of Service Delivered
Personal Care	Hour	11,262,974
Homemaker	Hour	9,737,920
Chore	Hour	1,373,180
Home-Delivered Meals	Meal	143,544,920
Adult Day Care/Health	Hour	8,620,404
Case Management	Hour	3,222,383
Congregate Meals	Meal	115,863,671
Nutrition Counseling	Hour	560,142
Assisted Transportation	1 way trip	2,632,177
Transportation	1 way trip	40,266,050
Legal Assistance	Hour	1,218,988
Nutrition Education	Session	2,015,724
Information and Assistance	Contact	13,421,755
Outreach	Contact	2,628,399
*Includes the 50 states, DC, Puerto Rico		

These unit measures are specific to each service and vary accordingly, such as the number of congregate and home-delivered meals, hours of personal care or the other in-home services, and number of one-way trips of transportation.

In 2000, the network on aging provided more than 143 million home-delivered meals to older persons and over 115 million meals in congregate settings. SUA and AAA transportation programs provided over 40 million one-way passenger trips, linking older persons to a range of community facilities and resources. The OAA network on aging provided 11.3 million hours of in-home personal care, 9.7 million hours of homemaker service, 8.6 million hours of adult day care/health, and 3.2 million hours of case management. SUA and AAA information and assistance programs made over 13 million contacts with older persons or their caregivers, and outreach programs made over 2.6 million contacts in the community to locate isolated older persons in need of services.

1.6.5 Units of Services Per Client

Beyond the total volume measures presented thus far, Table K identifies how much of each service clients actually use. The table shows the average number of service units that clients received during the course of a year and how this varied across the services. These figures are averages of all states' individual measures, which gives equal weight to each.

Table K. Units of Service Per Client, FY 2000*		
Service	Measure	Total Units of Service per Client
Personal Care	Hour	84
Homemaker	Hour	63
Chore	Hour	24
Home-Delivered Meals	Meal	143
Adult Day Care	Hour	321
Case Management	Hour	9
Congregate Meals	Meal	70
Nutrition Counseling	Hour	4
Assisted Transportation	1 way trip	35
*Includes the 50 states, DC, and Puerto Rico		

One emerging pattern is that certain services for a highly vulnerable population, such as adult day care/health, have a relatively high per-person utilization rate, given the extensive client needs this service addresses. At the same time, we see from Table F that this service involves a relatively small number of clients. For example, during the year 2000, clients received an average of 321 hours of adult day care/health services. Also, these per-person measures cover an entire year, even if the client received them for a shorter time period, in which case the utilization level would be even higher.

Each congregate meals program participant consumed an average of 70 meals during the year. However, we know from a 1996 evaluation of the Elderly Nutrition Program that there is a bimodal pattern of either relatively frequent attendance or only occasional participation in the congregate nutrition program. According to the evaluation, many of the congregate meals recipients participate quite frequently, and nearly 60 percent of those who attended a meal site on a given day usually participated four or more days per week.[5] The evaluation also showed that most participants reported spending a significant amount of time at the congregate site when they attended on a given day. Also, less than 10 percent reported receiving home-delivered meals regularly at some time in the past, showing the separate clientele each program serves, albeit, with similar demographic characteristics.

Each home-delivered meals program participant received, on average, 143 meals during 2000. As with other home-care programs, home-delivered meals included not only

[5] Ponza, M., J. C. Ohls, and B. E. Millen. *Serving Elders at Risk: The OAA Nutrition Programs, National Evaluation of the Elderly Nutrition Program, 1993-1995, Volume I*, U.S. Administration on Aging, Department of Health and Human Services, June 1996, p 64.

persons who were home bound and had long-term care needs, but also persons who received home-delivered meals on a temporary basis—for example, after discharge from a hospital.

According to the nutrition program evaluation, the majority of the home-delivered meals participants also received meals frequently. Ninety-five percent usually received five or more program meals per week. About 20 percent of home-delivered meals recipients reported participating in the congregate meals program regularly at some time during the past; however, most had not attended a congregate site at all during the past year. This also shows that, while the congregate and home-delivered meals programs serve persons with similar characteristics, very few persons participate in both programs. For both the congregate and home-delivered meals programs, clients may participate only on a short-term basis, but they do so frequently while they are receiving the services.

1.6.6 Services Unit Cost

Table L shows the mean (average) and median (midpoint) unit costs for the range of OAA services. These figures are based on total expenditures including OAA funds and the additional dollar expenditures the states reported for each service.

Increasingly, SUAs and AAAs use performance-based contracting to procure and monitor the delivery of services through providers. Standardization of accounting systems is essential for ensuring consistent information across providers, Planning and Service Areas (PSAs), and states for comparison purposes. Over time, the network on aging has made considerable strides in developing cost accounting systems that support performance management. However, substantial variation exists among and within the states and, therefore, the unit cost information in Table L must be viewed with caution.

Table L. Average Total Cost Per Unit of Service, FY 2000*			
		Unit Cost	
Service	Measure	Mean	Median
Personal Care	Hour	$13.66	$13.20
Homemaker	Hour	$12.39	$12.11
Chore	Hour	$14.25	$13.21
Home-Delivered Meals	Meal	$3.96	$4.01
Adult Day Care/Health	Hour	$9.16	$7.66
Case Management	Hour	$33.84	$31.09
Congregate Meals	Meal	$4.96	$4.80
Nutrition Counseling	Hour	$35.11	$22.34
Assisted Transportation	1 way trip	$6.90	$5.75
Transportation	1 way trip	$5.05	$4.84
Legal Assistance	Hour	$39.14	$34.85
Nutrition Education	Session	$16.60	$5.57
Information and Assistance	Contact	$10.89	$8.66
Outreach	Contact	$18.75	$14.89

*Includes 50 states, DC, Puerto Rico

This table presents the mean and median of unit costs for each of the 14 services during 2000. The unit costs were computed separately for each state by dividing the total service costs by the total units for each service. The mean and median were then determined from among these individual unit cost figures. This avoids having the unit cost figures dominated by a few large states, by giving equal weight to each state's figures. Outliers were eliminated by removing the two highest and two lowest state unit cost figures for each service.

The average unit cost for a congregate meal in 2000 was $4.96, and $3.96 for a home-delivered meal. These two services accounted for the largest expenditures under the OAA, consistent with the legislative earmarks of the Act. The third highest dollar allocation was for transportation where the mean cost per one-way trip was $5.05, and the median amount was $4.84. These services involved large groups of clients, and the per-unit costs were relatively low because expenses were spread across many participants. Other services, such as case management, involved only a few hours per client, but a high rate, and a comparatively small number of participants during the course of a year. While the total expenditure for this service was relatively low, the unit cost was comparatively high, at $33.54, because it required a one-on-one relationship between a skilled professional staff member and the client. Low staff-client ratios and high professional skill requirements also resulted in relatively large unit costs for legal assistance and nutrition counseling.

1.6.7 Average Service Cost Per Client

Another composite measure of performance is the total annual per-person cost for each service. Table M shows the total per capita expenditures for each of the nine services for which AoA collects person counts.

Table M. Average Total Service Cost Per Client, FY 2000

Service	Average Cost/Client
Personal Care	$1,062.68
Homemaker	$709.14
Chore	$321.70
Home-Delivered Meals	$572.51
Adult Day Care/Health	$2,360.73
Case Management	$272.87
Congregate Meals	$336.58
Nutrition Counseling	$91.64
Assisted Transportation	$204.00

As with the other tables on unit measures, these are averages across individual state cost per-client figures, giving equal weight to each and excluding outliers. The services with the highest costs per client involve the intensive, sustained assistance in adult day care/health, personal care, homemaker, and home-delivered meals. Case management, which has a high hourly rate, involves only a few hours per person per year, resulting in a low per-client cost.

1.7 How Many Staff Support OAA Programs, and What Are Their Responsibilities?

1.7.1 State Units on Aging

The State Units on Aging vary considerably in the size and scope of their responsibilities, and this influences the numbers and functional responsibilities of the staff who work there. Nationwide, only about one-third of the SUA funding comes from the OAA, and other funding sources and programs often influence staffing patterns to a considerable degree.

The SUAs also vary in terms of their organizational placement within state government. Approximately one-half of the SUAs are separate cabinet-level entities that report

directly to the governor, while others are part of a larger state entity, such as a state department of public welfare.

SUA Staffing

In 2000, SUAs reported a total of 3,467 staff, as Table N shows. Of the total, 9.1 percent fell into the executive/management category, consisting of staff who had responsibility for overall leadership and direction for the SUA.

Over 40 percent of the staff performed planning, development, and administration functions` associated with state and community programs on aging. These staff responsibilities included training, technical assistance, building partnerships with other state and community agencies, leveraging additional funds, policy and legislation development, and advocacy. This was a large and active segment of the SUA staff, and many of the specific activities of these employees are summarized in Appendix A, under Program Accomplishments.

Table N. State Unit on Aging Staffing, FY 2000*

Staffing Category	Total Staff	Percent Distribution
Executive/Management	317	9.1%
Planning	319	9.2%
Development	295	8.5%
Administration	784	22.6%
Service Delivery	435	12.5%
Service Access	606	17.5%
Other	120	3.5%
Clerical/Support	591	17.0%
Total SUA Staff	3,467	100.0%

*Includes 50 states, DC, PR

Over 12 percent of the staff provided direct services for the elderly, often as part of state adult protective services and other state-operated programs financed with funds other than the OAA.

Another 17.5 percent of staff were responsible for facilitating client access to services through such activities as statewide, toll-free information and assistance programs, case management provided by state social workers, and statewide outreach efforts to reach isolated older persons. About 3 percent had other professional staff responsibilities, and 17

percent performed clerical and other support functions. These figures represent full-time equivalents, and because of part-time staff, the total number is actually much higher.

SUA Staff Supported by OAA Funds

Table O shows that SUAs have leveraged considerable funding to employ staff for a range of planning and management functions. Only about one-third of the total staff (33.8 percent), were paid with Title III funds, while the remainder were supported by other sources of financing. This shows the extent to which OAA funding promoted the leveraging of considerable additional financial resources by SUAs.

Table O. SUA Staff Supported by OAA Funds, FY 2000*

Staffing Category	Total Staff	Number Paid with OAA Funds	Percent Paid with OAA Funds
Executive/Management	317	158	49.8%
Planning	319	158	49.5%
Development	295	130	44.1%
Administration	784	368	46.9%
Service Delivery	435	85	19.5%
Service Access	606	53	8.7%
Other	120	45	37.5%
Clerical/Support	591	175	29.6%
Total SUA Staff	3,467	1,172	33.8%

*Includes 50 states, DC, Puerto Rico

1.7.2 Area Agencies on Aging

The SUA is responsible for designating local PSAs which comprise a city, county, multiple counties, or other jurisdictions, consistent with the boundaries of units of general purpose local government or other state and local planning jurisdictions. The SUA then designates an Area Agency on Aging within the PSA to administer OAA allocations and other funding from the state. The AAAs prepare a plan for the development of programs and the provision of services for the aging in the PSA. Of particular importance is the building of partnerships with the many other agencies and programs to develop a comprehensive and coordinated system of services for the aging.

Relationship to General Purpose of Local Government

Nationwide, there were 650 AAAs in 2000, about two-thirds of which were public or quasi-public agencies such as city and county government or councils of government. The remaining one-third were private, nonprofit organizations; however, the boards of directors or advisory committees of these private AAAs were often local elected officials.

The AAAs have demonstrated an extraordinary record of achievement in making a small amount of Federal money under the OAA go a long way. The OAA funds provide the infrastructure necessary for AAAs to leverage millions of non-federal dollars from local governments, foundations, and participant and volunteer contributions. The wide range of services and funding sources managed by AAAs provide consumers with a broad range of choices, consistent with individual client needs.

The AAAs play a pivotal role in assessing community needs, developing responsive programs, and serving as strong advocates for improved services for older Americans and their caregivers. They often serve as a central entry point, providing assessment of multiple service needs, determining eligibility, arranging for and providing services, and monitoring the appropriateness and cost-effectiveness of care. They administer funds primarily through contracts with local providers furnishing these services at the community level. The AAA system is an example of an important step toward an integrated system of care that circumvents obstacles that seniors might otherwise have to overcome in receiving the services they need.[6]

AAA Staffing

The AAA staffing levels reflect the multiple administrative responsibilities and funding sources. Table P shows that, in 2000, AAAs reported a total of 21,951 staff. These figures represent full-time equivalents and, because of part-time staff, the total number is actually much higher.

Of the total paid staff, 5.7 percent performed executive management functions, and 14.4 percent were responsible for planning, program development, and administration of the local service delivery system. Another 39.7 percent of the staff provided direct services to the

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[6] Survey of Area Agency on Aging Support of Home and Community-Based, Long-Term Care Services, National Association of Area Agencies on Aging, April 1996

elderly and their family caregivers. In addition, 23.2 percent were responsible for facilitating access to a range of community services and benefits, through information and assistance, case management, and outreach activities. Of the total professional staff, 4.0 percent performed other functions, and 13 percent performed clerical and other support activities. The AAAs were supported by 17,342 volunteers.

Table P. Area Agency on Aging Staffing, FY 2000*		
Staffing Category	Total	Percent Distribution
Executive/Management	1,254	5.7%
Planning	589	2.7%
Development	511	2.3%
Administration	2,060	9.4%
Service Delivery	8,717	39.7%
Service Access	5,085	23.2%
Other	871	4.0%
Clerical/Support	2,864	13.0%
Total AAA Staff	21,951	100.0%
Volunteers	17,342	

*Includes 50 states, DC, Puerto Rico

AAA Staff Paid by OAA Title III

Table Q shows that less than half the staff at AAAs were paid with OAA funds. Through their own leveraging efforts, and by using the additional funding from the SUAs, AAAs were able to support a wide range of staff responsibilities. However, nearly two-thirds of the AAA core planning and management functions were supported by OAA funds, as were about one-half of the development, administration and service delivery (one-third of the service access and delivery functions). This shows the essential role OAA funds play in the core staff capacity and infrastructure of the Area Agencies.

Table Q. AAA Staff Supported by OAA Funds, FY 2000*			
Staffing Category	Total Staff	Number Paid with OAA Funds	Percent Paid with OAA Funds
Executive/Management	1,254	758	60.4%
Planning	589	376	63.8%
Development	511	271	53.0%
Administration	2,060	1,137	55.2%
Service Delivery	8,717	4,057	46.5%
Service Access	5,085	1,709	33.6%
Other	871	346	39.7%
Clerical/Support	2,864	1,174	41.0%
Total AAA Staff	21,951	9,828	44.8%

*Includes 50 states, DC, Puerto Rico

Long-Term Care Ombudsman Report FY 2001

Administration on Aging
Department of Health and Human Services

FY 2001 Long Term Care Ombudsman Report
With Comparisons of National Data for FY 1998-2001

Introduction

This report is submitted in compliance with Section 207(b) of the Older Americans Act of 1965 (OAA), as amended, which requires the Assistant Secretary for Aging to compile a report on information submitted by the states on activities of state long-term care ombudsman programs and provide the report to the congressional committees with jurisdiction over the OAA.

The data and other information presented and analyzed in this report are collected annually by AoA from state ombudsmen under the National Ombudsmen Reporting System (NORS). The data gathered and reported by the states are based on detailed data specifications established by AoA and ombudsman representatives across the country. AoA and state and local ombudsmen pay close attention to assuring that the statistical information reported under NORS is consistent. To further foster consistency in data collection and reporting, AoA addresses data issues annually in its national ombudsman conference, and has established a detailed ongoing action plan to ensure that ombudsmen across the country are continuously trained regarding the NORS definitions and concepts. AoA staff and contractors perform extensive verification and validation checks on the data submitted by ombudsmen prior to data dissemination and publication in reports such as this. Information obtained under NORS also includes narrative presentations by state ombudsmen who provide descriptions of the "priority long-term care issues" which their programs identified and worked on during the reporting period. Because of the nature of the form of reporting utilized, the information reflects the subjective views of the state ombudsmen which submit the reports. This information is summarized in the report.

This report provides data for fiscal year (FY) 2001 from all state ombudsman programs on the activities of those who participate in the Ombudsman Program at the state and local levels, and analyzes changes in the data since FY 1998, the date of the last report. The data from FY 2001 are the most current available. The central observation to be made from the data presented in the report is the significant increase in program activity over a three-year period, reflecting greater use of the Ombudsman Program by residents of long-term care facilities, their relatives, and by those who operate and work in those facilities. The following items illustrate this observation.

- Ombudsmen provided 35% more consultations to individuals in FY 2001 than they provided in FY 1998.
- Ombudsmen provided 58% more consultations to facility staff in FY 2001 than they provided in FY 1998.
- Ombudsmen responded to 35% more complaints in FY 2001 than in FY 1998.
- Ombudsmen resolved 77% of the complaints they handled in FY 2001, compared to 71% in FY 1998.

Long-term care ombudsmen are advocates for residents of long-term care facilities. They work to resolve individuals' problems with care and conditions, and to bring about changes at the local, state and national levels to improve care for all facility residents. Established under Section 712 of the Older Americans Act (OAA), ombudsman programs in every state and 596

local or regional areas carry out a variety of activities to assist residents to maintain a good quality of life and care in nursing homes, assisted living facilities, and other types of long-term care settings. Thousands of trained paid and volunteer ombudsmen provide an on-going presence in long-term care facilities, monitoring care and conditions and providing a voice for residents and their families.

Ombudsman responsibilities outlined in Title VII of the OAA include:

- identify, investigate and resolve complaints made by or on behalf of residents;
- provide information to residents about long-term care 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;
- educate and inform consumers and the general public regarding issues and concerns related to long-term care and facilitate public comment on laws, regulations, policies and actions;
- promote the development of citizen organizations to participate in the program; and
- provide technical support for the development of resident and family councils to protect the well-being and rights of residents.

The National Long-Term Care Ombudsman Resource Center, operated by the National Citizens' Coalition for Nursing Home Reform in conjunction with the National Association of State Units on Aging, provides on-call technical assistance and intensive training to assist ombudsmen in their demanding work. The Center is supported with funds appropriated by Congress and awarded by the Administration on Aging (AoA).

Report Highlights

Staffing, Providing Support to Volunteers and Local Programs

- There were 596 local and regional ombudsman programs in FY 2001. Most of these programs were located in area agencies on aging.

- The number of paid ombudsman staff increased from 927 full-time equivalents (FTEs) in FY 1998 to 1,029 FTEs in FY 2001.

- In 2001, there were 8,442 ombudsman volunteers certified to investigate complaints. Another 5,258 non-certified volunteers also served the program, for a total of about 13,700 volunteers nationwide in FY 2001.

- Providing technical assistance and training to paid and volunteer ombudsmen is a significant function of state-level ombudsman program staff. In 26 state entities, the program staff spent 30 percent or more of their time providing technical assistance to

volunteers and local programs. In the remaining 30 state entities, program staff used 20 percent or more of their time supporting and training ombudsmen.

- In FY 2001, ombudsman program staff provided or arranged for over 10,000 training sessions, totaling 46,050 hours, to their volunteers and staff.

Ombudsman Presence in Facilities and Empowerment of Families and Residents

- Ombudsman staff and volunteers visited over 85 percent of nursing homes on a regular basis, which is defined as at least quarterly and not in response to a complaint. In 20 states, ombudsmen regularly visited 100 percent of nursing homes; in another ten states, ombudsmen regularly visited 95 or more percent of the nursing homes in their state.

- Nationwide, ombudsman staff and volunteers visited over 44 percent of board and care and similar homes on a regular basis, not in response to a complaint. In 11 states, ombudsmen regularly visited 100 percent of these types of homes.

- In addition to their work on complaints, ombudsmen provided about 283,000 consultations to individuals in 2001. This was an increase of almost 16 percent over the previous year and 35 percent since FY 1998. The most frequent topics of consultation included: how to select and pay for a nursing home, residents rights and federal and state facility rules and policies.

- Ombudsman activity in long-term care facilities provides them with information that can be useful to facility managers and staff. Reflecting this phenomenon, ombudsmen provided 107,602 consultations to facility staff in FY 2001, a 58 percent increase over FY 1998. Consultations can address a wide range of issues, such residents' rights, observations about care issues, and transfer and discharge issues.

- In FY 2001, ombudsmen nationwide also:

    - met with resident councils (14,895 sessions) and family councils (4,317 sessions),
    - provided 8,499 training sessions to facility staff,
    - provided 8,995 community education sessions, and
    - participated in 10,003 facility surveys.

Services to Individuals (complaint investigation and resolution)

- In FY 2001, ombudsmen resolved or partially resolved 78 percent of nursing home complaints and 73 percent of board and care complaints to the satisfaction of the resident or complainant. The combined resolution rate of 77 percent for all facilities compares favorably with the 71% rate last reported for FY 1998.

- Ombudsmen nationwide opened 160,927 cases and closed 151,737 cases involving 264,269 individual complaints in FY 2001.

- From 2000 to 2001, there was an eight percent increase in cases opened, an 11 percent increase in cases closed, and a 14 percent increase in complaints.

- Seventy-nine percent of cases handled were associated with nursing home settings. The remaining 21 percent involved other settings, including board and care facilities, assisted living and other settings.

- Most cases were initiated by residents or friends and relatives of residents.

- Since 1998, there was a 28 percent increase in complaints handled by ombudsmen in nursing homes and a 45 percent increase in complaints handled involving board and care-type facilities.

- The top five nursing home complaints were about *call-light responses, staff attitudes, care plans, accidents and patient handling, and hygiene care.*

- The top five board and care and similar facilities complaints were about *menu quality, medication management, lack of respect for residents, discharge/eviction, and equipment/building disrepair.*

Long-Term Care Issues Addressed by State Ombudsmen

- State-level ombudsmen in 28 states spent at least 20 percent of their time meeting their statutorily mandated responsibility to analyze, comment on, monitor, and recommend changes to federal, state, and local laws, regulations, policies, and actions. Local ombudsmen in 17 states spent ten percent or more or their time on these activities.

- In response to OAA requirements and AoA instructions to "describe the long-term care issues which your program identified and/or worked on during the reporting year," insufficient numbers of staff to care for residents was the long-term care issue most frequently identified by state ombudsmen in their FY 2001 reports.

- Other issues which state ombudsmen frequently worked on their states included: discharge and transfer issues, lack of access to appropriate services or settings, inadequate regulation of assisted living and other non-nursing home facilities, and increased support of the Ombudsman Program.

Experiences of Ombudsmen

In FY 2001, ombudsmen resolved or partially resolved 77 percent of all complaints to the

satisfaction of the resident or complainant. The following cases illustrate how ombudsmen fulfilled this responsibility to assist residents and their families resolve individual problems.

- A California ombudsman helped relocate a woman from a personal care home where she had been neglected and abused by the care giver and abused by foster children living at the home. The woman was placed in a home where she received good care and was reunited with a guardian from whom she had been separated for years. Authorities investigated the care giver of the first home for operating without a current license and poor care of the foster children.

- A Colorado volunteer ombudsman assisted a group of personal care boarding home residents, who had complained to her about conditions in the facility and were being intimidated by the owner as a result, to present their grievances to the licensing agency, which cited the facility for numerous deficiencies. The director of the home resigned, and the residents expressed their relief and gratitude to the ombudsman and were more aware of their rights and how to protect them as a result of their action.

- The Connecticut ombudsman assisted a Medicaid-eligible resident who was being evicted from a Medicaid-certified nursing home because her rehabilitation paid for by Medicare was completed and she had been told upon admission that the facility provided "short term care only." However, she still required nursing home care was not able to return home. The ombudsman explained to the family that the resident would be able to remain at the facility because she still needed nursing home care, which was covered by Medicaid. Sixteen other residents had been moved out of the facility in a similar way. The facility was cited for inappropriate practices, waiting list law violation, inappropriate discharge planning and violation of resident rights; and the case was referred to the Attorney General for further action against the facility.

- The Georgia ombudsman assisted a family to recover over $12,000 for payments they had made for their mother's nursing home care. Due to changes in Medicaid rules, the Medicaid agency had owed them this amount for many months but had not paid them due to bureaucratic tangles.

- The Hawaii ombudsman visited with a man whose sister, who was his guardian, had persuaded his physician to discontinue dialysis treatment because, she said, "he was going to die anyway." The ombudsman discussed the consequences of not receiving dialysis with the resident and then asked him: "Do you want to die?" He said, "No, I want to live." The resident said he wanted the dialysis but was fearful that he would upset his sister. The ombudsman told him that he must express his wishes, helped him talk with his sister and assisted him in having the guardianship removed. The resident continued dialysis – and his relationship with his sister.

- The Massachusetts ombudsman received a call from the son of a newly-admitted resident

in a specialized dementia unit of a nursing home. The home had transferred his mother to a psychiatric facility because she had become agitated and struck out against her caregivers. Ombudsman staff intervened and arranged for a family meeting with facility staff, during which it was learned that the episode which led to the transfer was preceded by the staff's attempt to give the resident a shower. The son had told the facility on admission that the resident was frightened by the shower (not unusual for many dementia residents) and was more amendable to baths. As a result of ombudsman intervention, the woman was returned to the nursing home, where she was given baths as part of her regular care plan. There were no further lashing-out episodes.

- In Mississippi, a nursing aide left an incapacitated woman sitting in a rocking chair for four hours, dressed only in her underwear. The aide admitted she had left the woman, explaining that there were not enough staff on duty to care for all the residents who needed help. The ombudsman reported the problem to the licensing and certification agency, which failed to adequately investigate. When the ombudsman said she would notify the federal regulatory agency of conditions at the facility, the state agency cited the facility for deficiencies, and the staffing level and resident care improved.

- The daughter and legal guardian of a Montana nursing home resident insisted that her mother be tube-fed, but the mother wished to eat. After determining the resident's wishes, the ombudsman and facility social worker assisted the resident to revoke the guardianship. The daughter became threatening to her mother, secured a lawyer to file for guardianship and threatened the doctor with a lawsuit if the tube was removed. The ombudsman continued to provide the resident with support and encouragement. The doctor concurred that the resident had capacity to make these decisions, and the feeding tube was removed, after which time the resident ate well, lost no weight and felt good about making her own decision. The downside was that the daughter did not visit her mom for months following this occurrence.

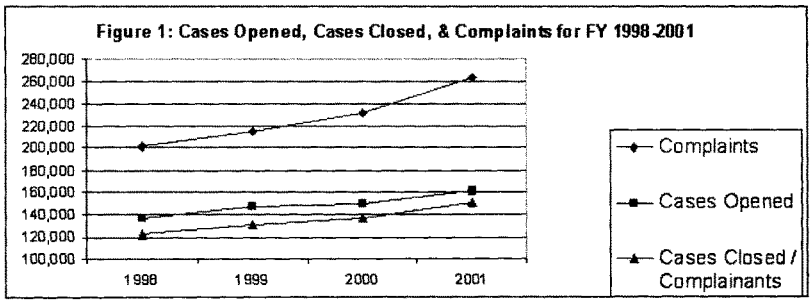
- A resident was discharged from a rural Texas facility where there was only one nursing facility and the closest neighboring facility was approximately 30 miles away. The facility was able to care for the resident but was discharging her due to actions on the part of family members, who the facility perceived as being demanding and displeased with the care provided by the facility. The Ombudsman Program supported the family in appealing the discharge notice, which was a very brief two-sentence statement that did not conform to state standards. The subsequent hearing resulted in a decision to overturn the discharge notice and to allow the resident to remain in the facility close to her family members. Had it not been for the ombudsman intervention, this resident, like many others in Texas, would have been discharged, and the family would have had to look elsewhere for care resources.

Cases and Complaints: FY 2001

Each inquiry brought to, or initiated by, the ombudsman on behalf of a resident or a group of residents is defined as a case. Each case may involve one or more problems, which are referred to as complaints. Except for reporting on the number of cases opened, all data submitted by the states in their annual reports to AoA are for closed cases.

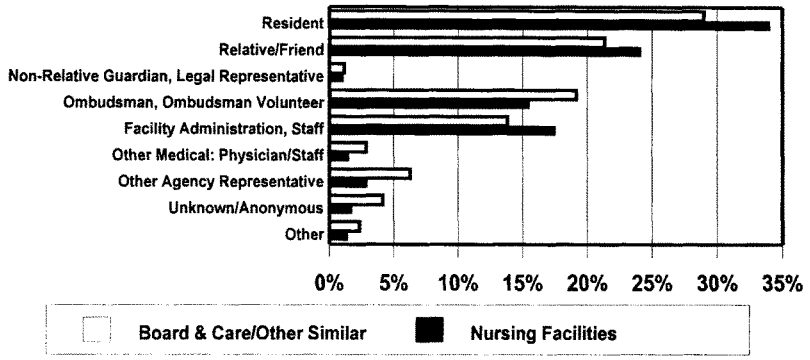
In FY 2001 ombudsmen opened 160,927 new cases and closed 151,737 cases, involving 264,269 complaints[1]. Figure 1 presents the data for FY 1998-2001 in cases opened and closed and in complaints associated with cases closed. There was an 18 percent increase in *cases* opened from 1998 to 2001 and an eight percent increase from 2000 to 2001. There was a seven to eight percent increase in *complaints* each year from 1998 to 2000, with a 14 percent increase from 2000 to 2001. The number of closed *cases* increased 11 percent from 2000 to 2001, five percent from 1999 to 2000 and seven percent from 1998 to 1999.

As shown in Figure 2, most complaints that were closed were filed by residents of facilities or by



friends or relatives of residents. In every year since 1998 there was an increase in percentage of complaints filed by residents, with that category eventually accounting for over a third of all complainants. There was a corresponding drop in percentage of complaints initiated by friends or relatives of residents during that time period and yet they still accounted for almost a quarter of all cases in 2001. Although it is difficult to draw conclusions from data such as these, it appears to be a positive indicator that residents themselves are increasingly using the services of Ombudsmen. The next highest groups filing complaints for all three years were ombudsmen and facility managers and staff.

Figure 2: Types of Complainants for Cases Closed FY 2001



The five most frequent nursing home complaints concerned:

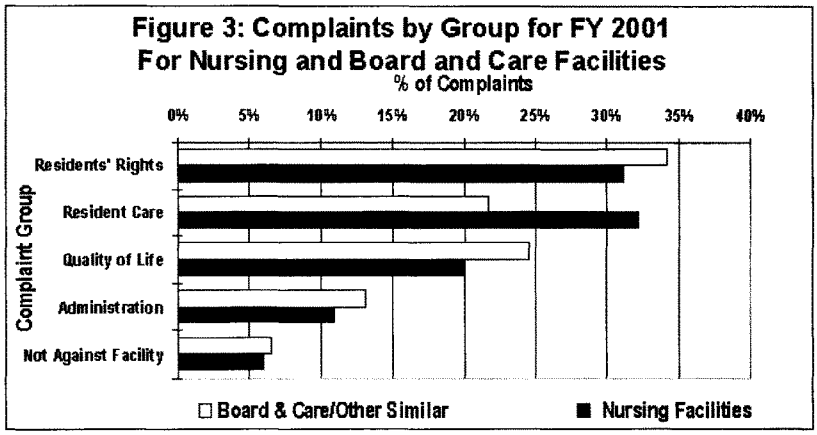
- unheeded responses to call lights, requests for assistance;
- lack of respect for residents, poor staff attitudes;
- problems with care planning and resident assessment;
- improper handling and accidents; and
- neglected personal hygiene.

The five most frequent complaints involving board and care, assisted living and similar facilities concerned:

- quality, quantity, variation and choice of food;
- medications - administration, organization;
- lack of respect for residents, poor staff attitudes;
- inadequate or no discharge/eviction notice or planning; and
- equipment or building hazards.

As illustrated in Figure 3, complaints about rights, care and quality of life constitute the major categories of problems addressed by Ombudsmen in nursing homes and in board and care facilities.

As shown in Table 4 on page 16, since 1998 the percent of complaints resolved or partially resolved to the satisfaction of the resident or complainant increased from 71 percent to 77 percent. In 2001 this figure was 78 percent for nursing homes, 73.3 percent for board and care homes and 76.7 percent for all settings, as illustrated in Figure 4 below. In 2001, 75.3 percent of all



complaints were verified.[2]

A four-year comparison of the top 20 specific nursing home complaints (Table 5 on page 17) indicates that the same care issues continued to dominate the top ranks from 1998 to 2001. In fact, the only change in the top five complaint categories was that by 2001 they accounted for an even larger proportion of the total complaints — from 18.6 percent in 1998 to over 20.5 percent in 2001.

The top five complaints for board and care, assisted living, and similar facilities – *menu quality, variation and choice* (J71), *medication administration and organization* (F44), *dignity, respect and staff attitudes* (D26), *lack of adequate discharge/eviction planning* (C19), and *equipment or building problems* (K79) – were virtually the same for the four years from 1998 to 2001. (See Table 6 on page 18, which shows the top 20 complaints.)

Other Ombudsman Activities in Addition to Complaint Work

Ombudsmen perform numerous functions in addition to investigating and resolving complaints. These include visiting facilities on a regular basis (not in response to complaints), participating in facility surveys conducted by state regulatory agencies, working with resident and family councils, providing community education, working with the media, training ombudsman staff and volunteers, training and consulting with managers and staff of long-term care facilities, and providing information and consultation to individuals. In addition to these activities, ombudsmen also monitor and work on laws, regulations, and government policies and actions.

These activities are listed in Table 12 on page 21, with national totals measuring the extent of ombudsman work on each of the activities, nationwide, for 1998-2001. As the data indicate, the ombudsman programs generally increased nursing facility visitation almost every year from 1998 to 2001, and in 2001 the percentage of these facilities visited regularly (not in response to complaints) rose to 85.4 percent. Visitation to board and care facilities remained around 44.5 percent since 1998, despite increases in numbers of beds and facilities.

There have been significant increases in consultations to individuals. In 2001, ombudsmen provided about 283,000 consultations to individuals on such topics as facility selection, residents rights and benefits, and long-term care facility regulations and policies. This was an increase of over 35 percent compared to the 209,476 reported for FY 1998.

Other ombudsman activities in 2001 directly related to consumer or resident and family empowerment include participation in 8,995 community education sessions, 14,895 meetings with family councils and 8,995 meetings with resident councils. These were all consistent with activity levels in past years.

In facility-related activities that also directly support residents and families, *ombudsman consultations to facilities increased over 58 percent since 1998,* rising from 68,066 to 107,602 in FY 2001.

Ombudsmen also participated in 8,499 sessions to train facility staff and participated in 10,003 facility surveys in 2001. The levels of both of these activities were comparable with activity levels in earlier years.

The number of ombudsman staff and volunteer participants receiving training arranged by the Ombudsman Program increased 74 percent, from 30,717 in 1998 to 53,591 in 2001. On average, each ombudsman staff and volunteer participated in three to four sessions in FY 2001. For 2001, state ombudsmen reported arranging for 10,001 training sessions for groups of ombudsmen and 46,050 training hours (for groups) These levels were similar to what was provided in prior years.

Ombudsman work with the media in 2001 fluctuated considerably from year to year because of changing circumstances. The 2001 figures of 5,811 interviews and 4,388 press releases were consistent with a typical year.

Ombudsman work on laws, regulations and government policies and actions is referred to as issues advocacy, which is discussed in the next section.

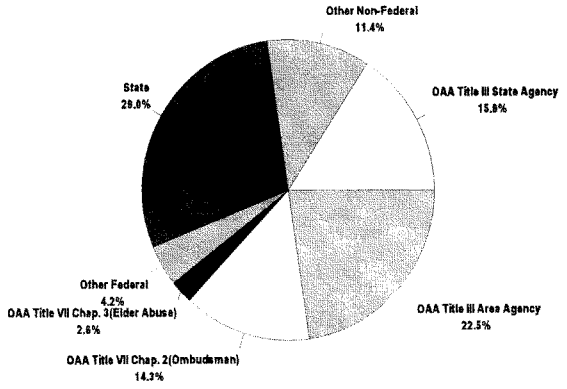
Program Operations

Resources

Total funding from all sources for the Ombudsman Program nationwide was $60,271,594 in FY 2001, an increase of $3.16 million above FY 2000, which was $6.73 million over 1999. The largest proportion of these increases were from state sources. The federal government continued to provide the most program funding in FY 2001 — $35.91 million, about 59.6 percent of total funding. Figure 4 below shows the percentages of funding, by source, for FY 2001.

Tables 7-9 on pages 18-19 show amounts and percentages from all sources for FY 1998-2001.

Figure 4: Sources of Funding for FY 2001
Long-Term Care Ombudsman Program



State and Local Programs

There were 596 local and regional ombudsman programs in FY 2001. As shown in Table 12 on page 21, there was little variation in placement of local programs from 1998 to 2001, and most regional programs continued to be located in area agencies on aging. (The shift of 21 entities from "Other" to "Regional Office of State Ombudsman Program" was simply a shift in organizational designation, not in organization placement.)

Most state long-term care ombudsman programs continued to be physically and organizationally located in the state units on aging, but in FY 2001 programs in 14 states (AK, CO, DC, FL, KS, ME, MI, OR, RI, VA, VT, WA, WI and WY) were either free-standing programs or located in private, non-profit agencies or a larger government ombudsman program. (In FY 2003, FL was moved to the state unit on aging, bringing the total to 13.)

Staff and Volunteers

The number of ombudsman staff increased from 926 full-time equivalents (FTEs) in 1998 to 1,029 FTEs in FY 2001. In every year except 2000, there was a four to six percent increase in staff FTEs.

The number of volunteers who were trained and certified to investigate complaints also increased, from 7,359 in 1998 to 8,442 in 2001. Table 11 on page 21 shows trends in staff and volunteer levels from 1995 through 2001.

Long-Term Care Issues Addressed by State Ombudsmen

Issues advocacy involves ombudsman work on laws, regulations and government policies and actions "that pertain to long-term care facilities and services, and to the health, safety, welfare and rights of residents" (OAA, Section 712 (h)(2). State ombudsmen were asked to describe the priority issues which their program had identified and/or worked on during the reporting period; barriers to resolution; and recommendations for system-wide changes needed to resolve the issue, or how the issue was resolved in their state. Thirty-six state ombudsmen responded to this question in 2001, thirty-nine in 2000, and thirty-five in 1999. State ombudsmen descriptions of these issues, actions they have taken to address them, and recommendations to resolve them are provided on the AoA web site referenced in the table of contents.

The issues that state ombudsmen most frequently report as ones they have identified and worked on include: insufficient numbers of staff to care for residents and lack of staff training. As in previous years, discharge and transfer issues were identified as a problem area by a large number of state ombudsmen. Other issues which state ombudsmen frequently reported that they worked on included: inadequate regulation of assisted living and other non-nursing home facilities, the need for support of the Ombudsman Program, and discharges and transfers due to closure of facilities.

Conclusion

Data from the nationwide Long-Term Care Ombudsman Program from 1998 to 2001 show notable increases in most aspects of ombudsman activity:

- Ombudsmen visited more facilities in FY 2001 than in FY 1998.
- In FY 2001, ombudsmen provided more consultations to both clients and their families and to the staffs of long-term care facilities.
- Ombudsmen handled a higher volume of cases and complaints in FY 2001, while resolving a higher percentage of the complaints they handled.

The ombudsmen achieved these results with only a slightly higher number of paid and volunteer workers. The data suggest that long-term care facility residents, their families and the staff of these facilities are increasingly using ombudsmen to address and resolve issues of patient care, patient rights, quality of care and facility administration. Over a four-year period, the percent of complaints which the Ombudsman Program resolved or partially resolved, to the satisfaction of the resident, increased from 71 in 1998 to 76.7 in 2001. In some ways this is the most significant of the productivity improvements because it reflects the program's impact in assisting individual residents in the institutional long-term care setting as well as its significant work in addressing major issues affecting large numbers of residents and potential residents of long-term care facilities.

PROGRAM DATA TABLES

Table 1: Types of Complainants for Cases Closed for FY 2001

Table 1: Types of Complainants for Cases Closed for FY 2001				
	All Facilities /Settings	Nursing Facilities	Board & Care/Other Similar	Non-Facility Settings
Total Complainants	151,737	122,063	26,665	3,099
Resident	32.89%	34.04%	28.98%	20.94%
Relative/ Friend	23.7%	24.15%	21.32%	26.69%
Non-Relative Guardian, Legal Representative	1.11%	1.09%	1.14%	1.76%
Ombudsman, Ombudsman Volunteer	15.96%	15.52%	19.13%	5.58%
Facility Administration, Staff	17.05%	17.53%	13.82%	26.19.%
Other Medical: Physician/ Staff	1.82%	1.52%	2.86%	4.99%
Other Agency Representative	3.67%	2.96%	6.27%	9.27%
Unknown/ Anonymous	2.21%	1.77%	4.16%	2.49%
Other	1.6%	1.43%	2.32%	2.09%

Table 2: Number of Complaints By Group for Fiscal Year 2001

Groups	Nursing Facilities		Board & Care/Other Similar		Non-Facility Settings
Total Complaints	209,663		50,152		4,454
Residents' Rights	65,372	31.2%	17,143	34.2%	
Resident Care	67,483	32.2%	10,902	21.7%	for non-facility
Quality of Life	41,757	19.9%	12,295	24.5%	
Administration	22,718	10.8%	6,545	13.1%	
Not Against Facility	12,333	5.9%	3,267	6.5%	

Table 3: Percentages of Complaints By Group, FY 1998-2001								
	Nursing Facilities				Board & Care/Other Similar			
Groups	1998	1999	2000	2001	1998	1999	2000	2001
Residents' Rights	32.8%	32.0%	30.5%	31.2%	35.8%	35.3%	34.7%	34.2%
Resident Care	31.5%	32.6%	32.6%	32.2%	20.6%	21.4%	23.0%	21.7%
Quality of Life	19.0%	19.5%	19.5%	19.9%	24.0%	24.1%	22.7%	24.5%
Administration	9.5%	9.9%	11.2%	10.8%	11.7%	12.2%	12.0%	13.1%
Not Against Facility	7.3%	6.0%	6.2%	5.9%	7.9%	7.0%	7.6%	6.5%

Table 4: Complaint Verification & Disposition

	1998	1999	2000	2001
Total Complaints	201,053	215,650	231,889	264,269
Complaints Verified				
Number	138,494	150,286	172,592	198,889
Percent	68.9%	69.7%	74.4%	75.26%
Disposition				
Requires government policy or regulatory change or legislative action to resolve	1.5%	1.7%	0.9%	1.2%
Not resolved to the satisfaction of resident or complainant	6.2%	5.9%	5.1%	5.8%
Withdrawn by resident or complainant	4.0%	3.5%	3.2%	2.7%
Referred to other agency for resolution, and report of final disposition not obtained	6.1%	5.9%	5.3%	5.3%
Referred to other agency for resolution, and other agency failed to act on complaint	1.0%	0.7%	0.8%	0.5%
No action needed or appropriate	10.2%	9.2%	8.1%	7.7%
Partially resolved but some problem remained	16.1%	15.5%	18.5%	18.7%
Resolved to satisfaction of resident or complainant	54.9%	57.6%	58.2%	58.0%

Table 5: Top 20 Complaints by Category for Nursing Facilities

			1998			1999			2000			2001		
Complaint Categories			Total	%	Rank	Total	%	Rank	Total	%	Rank	Total	%	Rank
Group		**See Table B-1 for Codes**	**163,540**			**172,662**			**186,234**			**209,633**		
F.	41	Call lights, requests for assistance	7,026	4.30%	1	7,644	4.43%	1	8,676	4.66%	1	10,126	4.83%	1
D.	26	Dignity, respect-staff attitudes	5,710	3.49%	4	6,453	3.74%	4	7,351	3.95%	4	8,838	4.22%	2
F.	42	Care plan/resident assessment	5,242	3.21%	7	6,412	3.71%	5	7,550	4.05%	3	8,572	4.09%	3
F.	40	Accidents, improper handling	6,032	3.69%	3	6,804	3.94%	3	7,675	4.12%	2	7,810	3.73%	4
F.	45	Personal hygiene	6,411	3.92%	2	7,110	4.12%	2	7,279	3.91%	5	7,712	3.68%	5
C.	19	Discharge/eviction-planning, notice, procedure	5,407	3.31%	6	5,455	3.16%	7	5,762	3.09%	7	6,699	3.20%	6
M.	97	Shortage of staff	4,887	2.99%	8	5,740	3.32%	6	6,625	3.56%	6	6,664	3.18%	7
J.	71	Menu-quantity, quality, variation, choice	4,554	2.78%	9	5,063	2.93%	8	5,540	2.97%	8	6,161	2.94%	8
F.	44	Medications-administration, organization	3,885	2.38%	11	4,397	2.55%	10	4,914	2.64%	9	5,734	2.74%	9
F.	48	Symptoms unattended, no notice to others of change in condition	3,818	2.33%	12	4,077	2.36%	12	4,617	2.48%	10	5,075	2.42%	10
A.	1	Physical abuse	5,426	3.32%	5	4,591	2.66%	9	4,350	2.34%	11	4,842	2.31%	11
E.	38	Personal property lost, stolen, used by others, destroyed	3,993	2.44%	10	4,229	2.45%	11	4,227	2.27%	12	4,680	2.23%	12
M.	100	Staff unresponsive, unavailable	3,248	1.99%	13	3,286	1.90%	15	3,700	1.99%	15	4,605	2.20%	13
K.	78	Cleanliness, pests	3,123	1.91%	14	3,458	2.00%	14	3,832	2.06%	13	4,199	2.00%	14
D.	27	Exercise choice and/or civil rights	2,851	1.74%	15	3,479	2.01%	13	3,803	2.04%	14	4,109	1.96%	15
M.	101	Supervision	1,925	1.18%	27	2,325	1.35%	24	3,326	1.79%	16	3,607	1.72%	16
A.	6	Resident to resident	2,577	1.58%	19	2,851	1.65%	17	3,034	1.63%	18	3,569	1.70%	17
K.	79	Equipment/building-disrepair, hazard, poor lighting, fire safety	1,952	1.19%	26	2,541	1.47%	20	2,899	1.56%	19	3,472	1.66%	18
F.	49	Toileting	2,720	1.66%	16	3,022	1.75%	16	3,093	1.66%	17	3,377	1.61%	19
K.	83	Odors	2,493	1.52%	21	2,544	1.47%	19	2,472	1.33%	24	3,230	1.54%	20
A.	3	Verbal/mental abuse	2,598	1.59%	18	2,601	1.51%	18	2,787	1.50%	20	3,171	1.51%	21
F.	52	Other: Care	2,717	1.66%	17	2,521	1.46%	21	2,645	1.42%	21	2,776	1.32%	22
E.	36	Billing/charges: notice, approval, questionable, accounting wrong or denied	2,428	1.48%	22	2,497	1.45%	22	2,589	1.39%	22	2,755	1.31%	23
A.	5	Gross neglect	2,551	1.56%	20	2,331	1.35%	23	2,372	1.27%	25	2,591	1.24%	25
P.	122	Legal-guardianship, conservatorship, power of attorney, wills	2,268	1.39%	24	1,974	1.14%	28	2,309	1.24%	26	2,465	1.18%	27

Table 6: Top 20 Complaints by Category for Board and Care Facilities

			1998			1999			2000			2001		
		Complaint Categories	Total	%	Rank	Total	%	Rank	Total	%	Rank	Total	%	Rank
Group		**See Table B-1 for Codes**	**34,696**			**37,953**			**41,397**			**50,152**		
J.	71	Menu-quantity, quality, variation, choice	1,792	5.16%	1	1,816	4.78%	1	2,060	4.98%	1	2,736	5.46%	1
F.	44	Medications-administration, organization	1,433	4.13%	2	1,682	4.43%	2	1,844	4.45%	2	2,234	4.45%	2
D.	26	Dignity, respect-staff attitudes	1,129	3.25%	4	1,336	3.52%	4	1,491	3.60%	3	1,915	3.82%	3
C.	19	Discharge/eviction-planning, notice, procedure	1,216	3.50%	3	1,365	3.60%	3	1,421	3.43%	4	1,691	3.37%	4
K.	79	Equipment/building-disrepair, hazard, poor lighting, fire safety	1,023	2.95%	6	1,300	3.43%	5	1,261	3.05%	5	1,486	2.96%	5
K.	78	Cleanliness, pests	927	2.67%	8	1,133	2.99%	6	1,091	2.64%	6	1,419	2.83%	6
F.	45	Personal hygiene	940	2.71%	7	914	2.41%	8	1,061	2.56%	7	1,163	2.32%	7
M.	97	Shortage of staff	720	2.08%	12	836	2.20%	12	1,001	2.42%	9	1,149	2.29%	8
F.	42	Care plan/resident assessment	664	1.91%	15	754	1.99%	15	1,025	2.48%	8	1,146	2.29%	9
E.	38	Personal property lost, stolen, used by others, destroyed	691	1.99%	14	789	2.08%	14	867	2.09%	12	1,080	2.15%	10
E.	36	Billing/charges: notice, approval, questionable, accounting wrong or denied	724	2.09%	11	825	2.17%	13	928	2.24%	10	1,061	2.12%	11
E.	37	Personal funds-mismanaged, access denied, deposits & other money not returned	887	2.56%	9	929	2.45%	7	806	1.95%	14	1,012	2.02%	12
D.	27	Exercise choice and/or civil rights	644	1.86%	16	719	1.89%	16	701	1.69%	17	1,009	2.01%	13
F.	40	Accidents, improper handling	698	2.01%	13	843	2.22%	10	886	2.14%	11	1,009	2.01%	13
A.	1	Physical abuse	1,044	3.01%	5	901	2.37%	9	847	2.05%	13	979	1.95%	15
A.	3	Verbal/mental abuse	797	2.30%	10	843	2.22%	10	802	1.94%	15	895	1.78%	16
F.	48	Symptoms unattended, no notice to others of change in condition	577	1.66%	17	644	1.70%	17	703	1.70%	16	895	1.78%	16
M.	100	Staff unresponsive, unavailable	465	1.34%	25	533	1.40%	24	552	1.33%	26	859	1.71%	18
M.	98	Staff training, lack of screening	483	1.39%	24	573	1.51%	20	603	1.46%	20	848	1.69%	19
A.	5	Gross neglect	562	1.62%	18	614	1.62%	18	649	1.57%	18	798	1.59%	20
K.	77	Air temperature, and quality	536	1.54%	20	612	1.61%	19	581	1.40%	21	772	1.54%	22
L.	93	Offering inappropriate level of care	518	1.49%	21	534	1.41%	23	520	1.26%	30	731	1.46%	25
P.	122	Legal-guardianship, conservatorship, power of attorney, wills	506	1.46%	23	458	1.21%	28	610	1.47%	19	591	1.18%	28
F.	51	Wandering-failure to accommodate/monitor	539	1.55%	19	557	1.47%	21	542	1.31%	28	569	1.13%	29

Table 7: Selected National Information FY 1998 through FY 2001

Category	FY 1998	FY 1999	FY 2000	FY 2001
Total Program Funding	$47,404,557	$51,380,290	$57,109,733	$60,271,594
Local Ombudsman Entities	587	587	591	596
Paid Program Staff (FTEs)	927	974	970	1,029
Volunteers				
Certified Volunteer Ombudsmen[1]	7,359	8,451	8,384	8,442
Other Volunteers	5,645	5,813	5,245	5,258
Total Volunteers	13,004	14,264	13,629	13,700
Licensed Facilities				
Board & Care/Similar[2]	41,292	43,943	43,102	45,723

[1] Individuals who have completed a training course prescribed by the state ombudsman and are approved by the state ombudsman to participate in the Ombudsman Program.

[2] Includes only those types of facilities which state ombudsman programs include within their purview under the requirement of

Table 8: Trends in the Ombudsman Program—FY 1998–2001

	FY 1998	FY 1999	FY 2000	FY 2001
Total Number Local Programs	587	587	591	596
Local Programs in AAA's	366	369	372	372
Total Number Complainants (Cases)	121.7	130.3	137.2	151.7
Total Number Complaints (000s)	201.1	215.7	231.9	264.3
Funding (in millions of dollars)				
Title III-B Funding				
Allotted by State & Area Agencies	20.1	21.3	22.2	23.2
Allotted by State Agencies	11.0	10.0	10.2	9.6
Allotted by Area Agencies	9.1	11.3	12.0	13.6
Title VII Chapter Two	4.5	6.6	7.9	8.6
Title VII, Chapter Three	1.8	1.9	1.6	1.5
All other Federal	1.1	1.7	2.1	2.6
All State	13.2	13.6	15.8	17.5
All Other Non-Federal	6.7	6.3	7.6	6.9
Total Funding	**47.4**	**51.4**	**57.1**	**60.3**

Table 9: Change in Funding: Federal vs. Non-Federal FY1998-FY2001				
	FY 1998	FY 1999	FY 2000	FY 2001
Total Funds (000,000)	47.40	51.38	57.11	60.27
Source of Funds				
Federal (000,000)	27.55	31.48	33.78	35.91
Non-Federal (000,000)	19.85	19.90	23.41	23.36
Federal (%)	58.12	61.26	59.15	59.59
Non-Federal (%)	41.88	38.74	40.85	40.41

Table 10: Designated Local Ombudsman Entities for FY 1998-2001

Year	Total	Area Agency on Aging	Other Local Government Entity	Legal Services Provider	Social Services Non-profit Agency	Freestanding Ombudsman Program	Regional Office of State Ombudsman Program	Other
FY 2001	596	372	14	26	85	12	70	17
FY 2000	591	372	3	28	87	15	48	38
FY 1999	587	369	19	27	80	16	47	29
FY 1998	587	366	18	30	79	18	46	30

Table 11 Ombudsman Program Staff and Volunteers
Totals for FY 1998-2001

	1998	1999	2000	2001
Paid program staff (FTEs)	**927**	**975**	**970**	**1,029**
working at state level	174	181	183	193
working at local level	752	793	787	836
Paid individuals working full-time on program	**679**	**757**	**767**	**839**
at state level	143	155	159	161
at local level	536	602	608	679
Volunteer ombudsmen trained and certified to investigate complaints	**7,359**	**8,451**	**8,384**	**8,442**
working at state level	217	215	301	288
working at local level	7,142	8,236	8,083	8,154
Other Volunteers (supporting roles, not involved in complaint work)	**5,645**	**5,813**	**5,245**	**5,258**
working at state level	66	51	94	56
working at local level	5579	5,762	5,151	5,202

Table 12: Other Ombudsman Activities

		1998	1999	2000	2001
Percent of all facilities visited not in response to complaints	*nursing homes*	78.3%	83.1%	79.0%	85.4%
	board & care	44.6%	47.2%	44.8%	44.4%
Participation in facility surveys	*surveys:*	9,533	12,215	9,403	10,003
Working with resident and family councils (attendance at meetings)	*resident council meetings:*	18,239	16,631	15,955	14,895
	family council meetings:	5,768	6,367	6,046	4,317
Providing community education	*sessions:*	9,307	10,231	11,567	8,995
Working with the media	*interviews:*	4,015	4,661	5,906	5,811
	press releases issued:	4,755	14,411	15,860	4,388
Providing training and technical assistance to staff and volunteers in the statewide ombudsman program	*training sessions:*	8,847	11,880	11,405	10,001
	hours:	44,235	52,670	47,537	46,050
	ombudsman trainees:	30,717	33,454	39,257	43,591
Providing training and consultation to managers and staff of long-term care facilities	*training sessions:*	7,298	9,260	8,139	8,499
	consultations:	68,066	75,862	94,435	107,602
Providing information and consultation to individuals (usually by telephone)	*consultations:*	209,476	210,276	244,535	282,964

Endnotes

1. In the National Ombudsman Reporting System (NORS) *case* is synonymous with *complainant* and is defined as "each inquiry brought to, or initiated by, the ombudsman on behalf of a resident or group of residents involving one or more complaints or problems which requires opening of a case file and includes ombudsman investigation, fact gathering, setting of objectives and/or strategy to resolve, and follow-up." *Complaint* is defined as "a concern brought to, or initiated by, the ombudsman for investigation and action by or on behalf of one or more residents of a long-term care facility relating to health, safety, welfare or rights of a resident. One or more complaints constitute a case."

2. Definition of *verified*: "It is determined after work (interviews, record inspection, observation, etc.) that the circumstances described in the complaint are substantiated or generally accurate." Within the Ombudsman Program it is understood and program instructions state that just because a complaint cannot be verified does not mean that it did not happen or that there is not a problem which requires explanation or resolution.

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides information to the Secretary on policy and management decisions for all groups served by the Department, including the elderly. ASPE oversees the Department's legislative development, planning, policy analysis, and research and evaluation activities and provides information used by senior staff to develop new policies and modify existing programs.

ASPE is involved in a broad range of activities related to aging policies and programs. It manages grants and contracts that focus on the elderly and coordinates other activities that integrate aging concerns with those of other population groups. For example, the elderly are included in studies of health care delivery, poverty, State-Federal relations and public and private social service programs.

ASPE also maintains a national clearinghouse which includes aging research and evaluation materials. The ASPE Policy Information Center (PIC) provides a centralized source of information about evaluative research on the Department's programs and policies by tracking , compiling, and retrieving data about ongoing and completed HHS evaluations. In addition, the PIC data base includes reports on ASPE policy research studies, the Inspector General's program inspections and investigations done by the General Accounting Office and the Congressional Budget Office. Copies of final reports of the studies described in this report are available from PIC.

During 2001-2002, ASPE undertook or participated in the following analytic and research activities that had a major focus on the elderly.

1. POLICY DEVELOPMENT—AGING

Federal Interagency Forum on Aging-Related Statistics

ASPE is a member of the Federal Interagency Forum on Aging-Related Statistics. The purpose of the Forum is to foster collaboration among Federal agencies that produce or use statistical data on the older population. Specifically, the Forum seeks to improve both the quality and use of data on the aging population by investigating questions of data availability, data quality, data measurement, and data integration; identifying information gaps and data inconsistencies; widening access to information on the aging population through periodic publications and other means; coordinating the development and use of statistical data bases among Federal agencies; promoting communication among data producers, researchers, and public policymakers; and addressing concerns regarding collection, access, and dissemination of data. The Forum was instrumental in gathering support for several important surveys of the aging U.S. population (e.g., the Health and Retirement Survey, the survey of Assets and Health Dynamics Among the Oldest-Old, and the Second Longitudinal Study of Aging) and produced several stand-alone reports including *Older Americans 2000: Key Indicators of Well-Being.*

2. RESEARCH AND DEMONSTRATION PROJECTS

Cash and Counseling: Next Steps

The major goals of this project are: (1) to identify the technical assistance needs of states and other organizations interested in replicating and enhancing or developing the infrastructure needed to implement a "Cash and Counseling" model of consumer-directed long-term care services; (2) to set up a Research and Technical Assistance Center (RTAC) to be run out of Boston College that will begin to assist states interested in developing individual and family-directed home and community-based services using CMS's recently announced "Independence Plus" waiver templates; and (3) to develop and implement a plan for conducting research related to the development of infrastructure for consumer-directed programs.

Contractor: Boston College

Funding:$1,124,498.96 (FY 02 $449,874.96; FY 03 $674,624)
End Date: September 30, 2006

Changes in the Prevalence of Disability in the Older American Population: Hypotheses and Evidence

A number of national surveys (e.g., the National Long-Term Care Survey, the Survey of Income and Program Participation, the Medicare Current Beneficiary Survey, and the Health and Retirement Survey/Asset and Health Dynamics of the Oldest-Old Survey) and other sources have shown that recent improvements in life expectancy have been accompanied by significant declines in the number of elderly persons with activity limitations and/or cognitive impairments. Efforts among researchers and policy makers are now shifting toward understanding the reasons for these declines and the potential policy implications. The purposes of this project are to (1) review the current literature on changes in elderly disability rates; (2) discuss the major hypotheses proposed by researchers to explain declines in the prevalence of elderly disability; and (3) review and critique the major studies and data used to evaluate one or more of these hypotheses.

Contractor: Duke University
Funding: $23,245 (FY 01 $23,245)
End Date: June 30, 2003

Designing a Blueprint for Our Future: A Guide for Consumer-Centered Models of Care in Nursing Homes

The purpose of this project is to develop a user-friendly book for states, providers, and consumers: (1) examining and documenting the new directions in consumer-centered care in nursing home settings; (2) exploring real or perceived regulatory barriers to designing consumer-centered models of care; (3) documenting innovative practitioners who have implemented consumer-centered activities and programs in their nursing homes; and (4) hypothesize about what is possible in the future in the provision of consumer-centered nursing home services and supports.

Contractor: The Lewin Group
Funding: $390,843 (FY 02 $249,626; FY 03 $141,217)
End Date: December 30, 2003

Designing a Private Long-Term Care Insurance Claimants "Admissions Cohort" Study

The purpose of this project is to design a research study of an admissions cohort of long-term care insurance claimants. Claimants were interviewed immediately upon triggering their benefits and followed for approximately 18 months. This project is part of a long-term research agenda being implemented by ASPE to better understand the circumstances or factors that motivate elders who have purchased private long-term care insurance benefits to file claims for benefits and how the presence of private insurance affects decision-making about formal services use for those who have been approved for benefits.

Contractor: Life Plans, Inc.
Funding: $175,000 (FY 01 $175,000)
End Date: September 30, 2002

Development of an Assistive Technology and Environmental Assessment Instrument for National Surveys

The overall purpose of this project is to develop, pilot, and disseminate an instrument to be used in national surveys to collect assistive device and environmental information from working-age adults with disabilities as well as older persons living in the community. The project will include an analysis of data from the pilot study, and produce a report detailing the process, pilot work, findings, and final instrument. The dissemination phase will include a meeting of the major investigators on national health and disability surveys--both government and private (e.g., National Health Interview Survey, Current Population Survey, National Long-Term Care Survey, Panel Study of Income Dynamics, Health and Retirement Survey)--to

present the results of the pilot study and discuss ways of appropriately incorporating all or part of the instrument in various surveys.

Contractor: Madlyn and Leonard Abramson Center
Funding: $550,000 (FY 02 $550,000)
End Date: September 30, 2004

Electronic Health Information in Post-Acute and Long-Term Care

Post-acute care (PAC) and long-term care (LTC) have requirements for Electronic Health Information Systems (EHIS) that differ from acute care and ambulatory care, where most development is currently taking place. PAC and LTC primarily include care that is provided in skilled nursing facilities/nursing homes, home health agencies, and acute rehabilitation hospitals. This project examines EHIS for PAC/LTC particularly in sites that are fully integrated across acute and PAC/LTC and addresses several research questions including the following: (1) To what extent have acute care settings that employ the most robust EMR/EHIS extended into PAC/LTC? If they haven't extended, why not? (2) To what extent are the most robust EMR/EHIS in PAC/LTC interoperable with acute care settings and physician offices? If they do not share information with these settings, why not? (3) What are the functional requirements for EMR/EHIS in PAC/LTC? The project includes a literature search and discussions with stakeholders involved in EHIS activities in the acute and PAC/LTC settings. Concurrently, we will develop a conceptual framework that will form the basis for specifying system requirements and evaluating extant systems.

Contractor: University of Colorado Health Sciences Center
Funding: $479,580 (FY 02 $437,102, FY 03 $75,200)
End Date: June 30, 2004

Estimating the Size and Characteristics of the Long-Term Care Population

With Americans' increasing reliance on home and community-based services and assisted living facilities, it is critical for policy makers to monitor trends in long-term care use and the characteristics of the population outside of the traditional nursing home. Currently, there are two primary sources of comprehensive information on the living arrangements of older Americans and their use of long-term care services: the decennial Census and surveys specifically designed to collect data on the long-term care population (e.g., the National Nursing Home Survey [NNHS], the Medicare Current Beneficiary Survey [MCBS], National Long-Term Care Survey [NLTCS]). Whether persons are classified as residing in an institution or not is greatly dependent on how the sampling frame is constructed (in the case for surveys) and/or how a person's living arrangements are determined. Unfortunately, the Census and surveys frequently use different data collection methods and approaches to categorizing living arrangements and long-term care service use. As a result, estimates of the number of persons in certain residential settings vary widely. For example, based on the 1996 MCBS, the number of older Americans living in assisted living facilities is approximately 420,000; however, the corresponding estimate from the 1999 NLTCS is nearly twice as high (810,000). With input from the Federal Interagency Forum on Aging-Related Statistics, this project will conduct a series of analyses of the most recent data to estimate and interpret variations in the size and characteristics of the long-term care population in different residential settings.

Contractor: The Urban Institute
Funding: $175,000 (FY 02 $175,000)
End Date: December 31, 2003

Handbook of Medicaid Options for Community-Based Service Coverage of Working-Age Adults with Severe Mental Disorders

The purpose of this project is to develop a handbook that describes and clarifies Medicaid's federal rules and regulations governing the application of Medicaid Options--particularly Rehabilitation, Targeted Case Management, and Clinic Options--in creating an array of community-based mental health

services, such as those constituting an Assertive Community Treatment (ACT) program, for working-age adults with severe mental disorders. The Handbook also will provide examples of the range of community-based services for this population as drafted by states and supported by Medicaid as a practical guide for application by other states. Although Medicaid is not the only funding source for services for this population, Medicaid is important in providing community-based care for adults with severe mental disorders.

Contractor: Research Triangle Institute
Funding: $249,976 (FY 02 $249,976)
End Date: January 31, 2004

Health Promotion and Aging: A Blueprint for Change for the 21st Century

The purpose of this study is to describe health promotion, disease prevention and health education activities for the elderly, highlighting the range of these efforts throughout the Department. One of the primary goals of this effort will be to identify ways the Department can enhance health promotion/disease prevention programs for the elderly. This project will analyze health promotion/disease prevention strategies that seek to: (1) reduce behavioral risk factors; (2) encourage the use of preventive services; (3) strengthen the role of public health agencies in encouraging healthy behaviors; and (4) educate the elderly, their families and elder care providers in disease prevention and health promotion.

Contractor: Research Triangle Institute
Funding: $205,760 (FY 02 $205,760)
End Date: August 31, 2004

Inventory of Long-Term Care Residential Places

This is an interagency agreement between ASPE and the National Center for Health Statistics to support the development of statistical and analytic reports from the forthcoming interagency project on Inventory of Long Term Care Residential Places. Although the National Nursing Home Survey collects data on nursing home residents, there is no comparable mechanism for collecting data on assisted living and related facilities. The inventory represents the first step in expanding the National Nursing Home Survey to include other long-term care places.

Contractor: Social Scientific Systems
Funding: $75,000 (FY 01 $75,000)
End Date: September 30, 2003

Lexicon of Technologies in Long-Term Care Settings

Comprehensive and systematic information on existing and emerging technologies in long-term care settings is not currently available, and there is no existing framework to document and evaluate these systems' ease of use, cost benefit ratio, and contribution to the quality of life of service recipients and quality of care they receive. In addition, the barriers to the implementation of such technologies in long-term care settings have not been systematically identified. This project aims at filling these important information gaps. Thus, the main purpose of this project is to construct and maintain a searchable, updateable lexicon (i.e., a comprehensive database) of existing and emerging technologies in long-term care settings that will be made available through a web-based interface. The project also aims at identifying and examining legal, financial, and social barriers to the process of implementing these technologies in long-term care settings.

Contractor: Madlyn and Leonard Abramson Center
Funding: $436,600 (FY 02 $436,600)
End Date: September 30, 2004

Long-Term Care Insurance Claimants "Admissions Cohort" Study: Data Collection and Analysis Phase

The purpose of this project is to enhance ASPE's understanding of the circumstances or factors that motivate elders who have purchased private long-term care insurance to file claims for benefits, and how the availability of insurance coverage influences their service-seeking behavior after they have been approved to receive benefits. The findings of this project are expected to help the government assess the future potential of private long-term care insurance as a method of financing long-term care services, especially home and community-based services.

Contractor: LifePlans, Inc.
Funding: $541,859.25 (FY 02 $541,859.25)
End Date: December 31, 2004

Managed Long-Term Care Study

The number of Medicaid beneficiaries enrolled in managed care grew from 4.8 million in 1993 to 16.6 million in 1998. During 1998, there were more Medicaid beneficiaries in managed care than there were in fee-for-service. Given the strength of the movement toward managed care, states have begun to experiment with managed long-term care. Selected states have developed and implemented managed long-term care programs for a wide set of beneficiaries. Arizona, Michigan Texas, and Wisconsin are currently operating such programs and are planning on expansion. While many of these programs are being evaluated, very little is known about the public and private organizations that are entering this new managed care market. This project aims to get a better understanding of what organizations are moving into this arena and a preliminary look at how they manage the provision of long-term care services as compared to the fee-for-service models with which we have become familiar.

Contractor: MEDSTAT Group
Funding: $201,348.86 (FY 02 $201,348.86)
End Date: January 30, 2004

Market Changes of the Supply and Use of Home Health Services: 1996-2000

The purpose of this project is to evaluate changes in the Medicare home health service delivery system over a five-year period between 1996 and 2000. During this period, Medicare home health services have experienced several major changes that led to a significant reduction in the number of home health care providers and decline in the use of Medicare home health services. Findings from the study will assist ASPE in its continued monitoring efforts of the home health benefit as well as provide recommendations for future policy options.

Contractor: The Urban Institute
Funding: $299,828 (FY 01 $299,828)
End Date: May 31, 2003

Medicare Services Utilization by Beneficiaries with Private Long-Term Care Insurance Coverage

The purpose of this project is to link Medicare utilization data to other data elements for the community-based claimants included in the Long-Term Care Insurance Panel. This will be done in an effort to get a better understanding of the relationship between private long-term care insurance and the use of Medicare financed services. The project examines the relationship between long-term care and acute or post-acute care service utilization prior to, during and after the time of claim. The research includes comparisons to similarly disabled noninsured community residents in the general population using the 1994 National Long-Tern Care Survey sample.

Contractor: LifePlans, Inc.
Funding: $34,000 (FY 01 $34,000)
End Date: December 7, 2001

Monitoring Trends in Elderly Disability and the Use of Assistive Devices

This project will analyze the 1984-1999 National Long-Term Care Survey with the dual purposes of: (1) examining the relationship between declines in elderly disability and health care utilization and costs, using Medicare claims data; and (2) describing changes in the elderly's use of assistive devices for activities of daily living and instrumental activities of daily living.

Contractor: The Urban Institute
Funding: $248,924.00 (FY 02 $248,924.00)
End Date: July 31, 2004

National Initiative to Improve the Recruitment and Retention of the Paraprofessional Workforce in Long-Term Care

ASPE has launched a special development initiative to address the critical shortage of paraprofessional workers across the full spectrum of long-term care settings. This project is a partnership between the Institute for the Future of Aging Services, a policy research center within the American Association of Homes and Services for the Aging, and the Paraprofessional Health Care Institute, a national nonprofit healthcare employment and advocacy organization. This collaborative project aims to: (1) develop specifications for a new program of demonstration grants designed to bring about changes in provider practice and public policy to reduce high rates of vacancy and turnover among paraprofessional staff and improve the quality of their jobs; (2) design a public awareness strategy to increase public recognition of the role of the direct care worker in long-term care; (3) create a publicly available database of promising provider practices designed to improve worker recruitment, retention and job quality and related research and evaluation studies; (4) and develop an applied research plan to investigate the nature, causes and impact of direct care workforce problems and support studies of workforce issues (e.g., an ethnographic study comparing workers who continue in the long-term care field for many years and workers who choose to leave).

Contractor: Institute for the Future of Aging Services, Association of Homes and Services for the Aged
Funding: $1,050,000 (FY 01 $600,000; FY 02 $450,000 includes $100,000 from DOL)
End Date: June 30, 2004

Naturally Occurring Retirement Communities (NORCs): Implications for Aging and Long-Term Care Policy

ASPE has an interest in the policy implications of fostering the NORC concept as a way of encouraging aging in place, supporting people at home and in the community, and conceivably forestalling unnecessary institutional acute or long-term care. The purpose of this project is to provide specific formative research on implementation issues associated with organizing services for NORCs, and to highlight broader policy implications of identifying and making use of the NORC concept as a way of organizing community-based care in response to an aging population.

Contractor: The Urban Institute
Funding: $200,000 (FY 02 $200,000)
End Date: March 2004

Overview of State Long-Term Care Reforms

The purpose of this project is to provide a descriptive study for all 50 states that: (1) summarizes and synthesizes state long-term care reforms into a series of themes; (2) identifies the types of processes used by states to develop and implement their reforms; and (3) identifies the federal/state approvals and the financial and other resources necessary for implementation.

Contractor: George Washington University
Funding: $360,226 (FY 01 $260,226; FY 03 $100,000)
End Date: September 2004

Patterns of Medicare Home Health Services Use Among Chronically Disabled and Non-Chronically Disabled Elderly: 1989, 1994 and 1999

This study uses Medicare claims for home health services appended to the 1989, 1994 and 1999 National Long-Term Care Surveys to explore changing patterns of home health use among the chronically disabled and non (chronically) disabled elderly over this ten-year period. Significant Medicare coverage and/or payment policy reforms with respect to home health services were implemented between 1989 and 1994, and between 1994 and 1999. Therefore, these datasets are well-suited to measuring the impact of the Medicare policy changes on patterns of service use and costs.

Contractor: MEDSTAT Group
Funding: $150,272 (FY 01 $150,272)
End Date: November 30, 2003

Review of Mental Health and Cognitive Impairment Measures in Surveys

The purpose of this project is to review survey elements for mental health and cognitive impairments that have been utilized in population-based national surveys. The project: (1) reviews existing measures of mental disorders, cognitive or mental impairments--distinguishing diagnosis from impairment and symptomatology--for children and adolescents, working-age adults, and the elderly to identify common elements and their purpose(s); (2) documents the validity and reliability of the measures, as identified in currently existing sources, for the three age groups; (3) calculates the prevalence identified by the elements within the survey for working-age adults and the elderly using appropriate methods; and (4) determines the associations of these elements with disabilities in activities of daily living, in instrumental activities of daily living and other selected disabilities.

Contractor: Westat, Inc.
Funding: $202,483 (FY 01 $202,483)
End Date: October 31, 2003

State Innovation Grants

In fiscal year 2002, ASPE awarded a total of fifteen grants to states to support innovative health and human services delivery. The goals of the initiative are to increase the effectiveness of health and human services by fostering innovative approaches to service delivery, and to share information gained through this program with other state agencies and interested parties so that they may learn about, and potentially replicate, innovative approaches. Two of these grants are focused on the elderly population. The grant to Arkansas Department of Human Services is used by the state to apply the Cash and Counseling Demonstration program model to provide consumers with a new option to exchange Medicaid nursing home benefits for a daily cash allowance. Participants in the program, who are individuals living in a nursing home who prefer a non-institutional setting, may use the cash allowance to purchase the support services they require to live successfully in the community. This project builds on the established home and community-based services foundation and offers participants additional options for consumer-directed care. The grant to Maryland Department of Aging is used by the state to convene an interagency steering committee to (1) discuss approaches to providing integrated services to older persons residing in state housing including the collection of information via a survey and compilation of other data, and (2) develop an intervention plan to implement integrated service delivery strategies.

Grantees: Arkansas Department of Human Services; Maryland Department of Aging
Funding: $460,557 (FY 02 $460,557; $410,557 to Arkansas, $50,000 to Maryland)
End Date: September 30, 2004 (Arkansas), February 29, 2004 (Maryland)

State Nursing Home Quality Improvement Efforts

The purpose of the project is to inform federal and state policymakers of some of the activities that have been undertaken by some states to improve the quality of nursing home care. The project

provides both a broad overview of the efforts undertaken by states and a more detailed description of state quality improvement activities in selected states. The project is intended to address the following research questions: (1) What are the characteristics of state initiated quality improvement programs? (2) What are the objectives of the state initiated quality improvement programs? Are all facilities or only some facilities targeted? What interventions do states employ? (3) How have states implemented the quality improvement program? (4) What is known about the effectiveness of the quality improvement program? This project also examines the terms, concepts, and relationships needed to measure quality in the domains of incontinence, pain, and pressure sores.

Contractor: Abt Associates and MAYO Foundation
Funding: $420,779 (FY 01 $415,979, FY 02 $4,800)
End Date: May 15, 2003

Study of Financial Exploitation of Elders

To respond to the 2000 re-authorization of the Older Americans Act, ASPE and the Administration on Aging co-funded an examination that will serve as an initial framework for Congress and the Department of Health and Human Services as each considers the policy implications of financial exploitation. Through a synthesis of the literature, consultation with subject matter experts, and field research, the project aims to: (1) develop a conceptual framework that can guide an operational definition of financial exploitation of older people (within the larger context of elder abuse) to begin to describe reasonable expectations for recognizing and addressing it where it happens; (2) begin considering a national estimate of prevalence; (3) identify and describe effective policies and approaches to identification, prevention and intervention; and (4) recommend future directions in policy and research for the Congress, federal agencies, state legislatures and agencies, and other groups.

Contractor: Research Triangle Institute
Funding: $300,000 (FY 02 $300,000; $100,000 from ASPE; $200,000 from AoA)
End Date: March 2004

Using Medicaid to Cover Services in Assisted Living and Residential Care Settings

The purpose of this project is to examine current state policies and practices regarding Medicaid funding for services provided in assisted living settings. An understanding of these policies and practices is needed to inform policymakers about Medicaid's current and potential role in providing services in this increasingly popular residential setting.

Contractor: Research Triangle Institute
Funding: $149,375 (FY 01 $149,375)
End Date: August 2002

Using MSIS Data for Analysis of Medicaid Long-Term Care and Mental Health Expenditures

The purpose of this project is to assess the accuracy and usefulness of the 1999 Medicaid Statistical Information System (MSIS) data by performing three analyses: (1) an analysis of the characteristics of Medicaid beneficiaries enrolled in managed care in all states; (2) an analysis of the characteristics of Medicaid beneficiaries using mental health services in one state, including the types of services that they use and program expenditures; and (3) an analysis of the characteristics of Medicaid beneficiaries who use long-term care services in three states, including the types of the services that they use and program expenditures. The accuracy of the data is determined by comparing them to existing sources of aggregate data on Medicaid program expenditures. The usefulness of the data is assessed in terms of their ability to describe enrollees in Medicaid managed care plans, and users of long-term care and mental health services, which cannot now be done with aggregate statistics.

Contractor: Mathematica Policy Research
Funding: $459,978 (FY 01 $459,978)
End Date: October 2003

ADMINISTRATION FOR CHILDREN AND FAMILIES
TITLE XX SOCIAL SERVICE BLOCK GRANT PROGRAM

The Social Services Block Grant (SSBG) is a Department of Health and Human Services grant program administered by the Office of Community Services (OCS) in the Administration for Children and Families (ACF).

The SSBG, which is found at Title XX of the Social Security Act, constitutes the major source of Federal funding for social services programs in the States. The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) amended Title XX to establish the SSBG program under which formula grants are made directly to the 50 States, the District of Columbia, and the Territories, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands, for use in funding a variety of social services best suited to the needs of individuals and families residing within the State. The SSBG statute also permits States to transfer up to 10 percent of their block grant funds to other block grant programs for support of health services, health promotions and disease prevention activities, and low-income home energy assistance.

In the welfare reform legislation passed in 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (Public Law 104-193), States are allowed to transfer up to 30 percent of their Temporary Assistance to Needy Families (TANF) grant to SSBG and the Child Care Development Block Grant programs. The Balanced Budget Act of 1997 (Public Law 105-33) provided that the TANF transfer to SSBG would be up to 10 percent of a state's TANF grant. The Transportation Equity Act of 1998 (Public Law 105-178) reduced the amount available for transfer from TANF to SSBG to 4.25 percent beginning in Fiscal Year 2001. However, in spite of the reduction authorized in the Transportation Equity Act, each fiscal year since 2001, the transfer percentage remained at 10 percent as the Congress provided authority to retain the transfer amount at 10 percent in each years budget.

Under the SSBG, Federal funds are available without a matching requirement. In fiscal year 2002, a total of $1.7 billion was allotted to States. Within the specific limitations in the law, each State has the flexibility to determine what services will be provided, who is eligible to receive services, and how funds are distributed among the various services within the State. State and/or local Title XX agencies (i.e., county, city, regional offices) may provide these services directly, or purchase them from qualified agencies and individuals.

A variety of social services directed at assisting aged persons to obtain or maintain a maximum level of self-care and independence may be provided under the SSBG. Such services include, but are not limited to adult day care, adult foster care, protective services, health-related services, homemaker services, housing and home maintenance services, transportation, preparation and delivery of meals, senior centers, and other services that assist elderly persons to remain in their own homes or in community living situations. Services may also be offered

which facilitate admission for institutional care when other forms of care are not appropriate. Under the SSBG, States are not required to submit data that indicate the number of elderly recipients or the amount of expenditures provided to support specific services for the elderly. States are required, prior to the expenditures of funds under the SSBG, to prepare a report on the intended use of the funds including information on the type of activities to be supported and the categories or characteristics of individuals to be served. States also are required to report annually on activities carried out under the SSBG. Beginning with fiscal year 1989, the annual report must include specific information on the numbers of children and adults receiving services, the amount spent in providing each service, the method by which services were provided, i.e., public or private agencies, and the criteria used in determining eligibility for each service.

The most recent expenditure report data available is for FY 2001. Based on an analysis of post-expenditure reports submitted by the States for fiscal year 2001, the list below indicates the number of States providing certain types of services to the aged under the SSBG.

Services	Number of States[1]
Home-Based Services[2]	37
Adult Protective Services	32
Transportation Services	23
Adult Day Care	25
Health Related Services	15
Information and Referral	16
Home Delivered	15
Congregate Meals	11
Adult Foster Care	13
Housing	11

In enabling the elderly to maintain independent living, most States provide Home-Based Services which frequently includes homemaker services, companion and/or chore services. Homemaker services may include assisting with food shopping, light housekeeping, and personal laundry. Companion services can be personal aid to, and/or supervision of aged persons who are unable to care for themselves without assistance. Chore services frequently involve performing home maintenance tasks and heavy housecleaning for the aged person who cannot perform these tasks.

States also provide Adult Protective Services to persons generally sixty years of age and over. These services may consist of the identification, receipt, and investigation of complaints and reports of adult abuse. In addition, this service may involve providing counseling and assistance to stabilize a living arrangement. If appropriate, Adult Protective Services

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[1]Includes 50 States and the District of Columbia.
[2]Includes homemaker, chore, home health, companionship, and home

may include the provision of, or arranging for, home based care, day care, meal service, legal assistance, and other activities to protect the elderly.

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

The Low Income Home Energy Assistance Program (LIHEAP) is a Department of Health and Human Services block grant program administered by the Office of Community Services (OCS) in the Administration for Children and Families (ACF).

LIHEAP helps low-income households meet the cost of home energy. The program is authorized by the Omnibus Budget Reconciliation Act of 1981, as amended most recently by the Coats Human Services Reauthorization Act of 1998 (P.L. 105-285). In fiscal year 2001, all 50 states, the District of Columbia, five territories, and 128 tribes and tribal organizations received grants amounting to approximately $2.255 billion, including $1.4 billion in regular block grant funds and $855 million in emergency contingency funds.

In fiscal year 2002, $1.7 billion was available. In addition, $300 million in emergency contingency funds was available if the President decided to release some or all of the funds because of weather, supply shortages, or other energy emergencies. In fiscal year 2002, $100 million in emergency contingency funds was released.

Federally-recognized and state-recognized Indian tribes, including Alaska native villages, may apply for direct LIHEAP funding. The amount to be reserved from a states allotment for a direct grant to a tribe will be based on the ratio of eligible tribal households to total eligible households in the state, or a larger allotment amount agreed on by the tribe and state.

Of the $1.7 billion appropriated for fiscal year 2002, $27.5 million was earmarked for leveraging incentive awards, to reward grantees that add non-Federal resources to help low income households meet their home heating and cooling needs. Up to 25% of the leveraging incentive awards, or $6,875,000, was used to fund grants to LIHEAP grantees under the Residential Energy Assistance Challenge Option Program (REACH) to develop innovative programs to reduce the energy vulnerability of LIHEAP-eligible households.

LIHEAP block grants are made to States, territories, and eligible applicant Indian Tribes. Grantees may provide heating assistance, cooling assistance, energy crisis interventions, and low-cost residential weatherization or other energy-related home repair to eligible households. Grantees can make payments to households with incomes not exceeding the greater of 150 percent of the poverty level or 60 percent of the State's median income.[3] Most households in which one or more persons are receiving benefits from the Temporary Assistance to Needy Families (TANF)

[3]Beginning with fiscal year 1986, States are prohibited from setting income eligibility levels lower than 110 percent of the poverty level.

block grant, Supplemental Security Income, Food Stamps or need-tested veterans' benefits, may be regarded as categorically eligible for LIHEAP.

Low-income elderly households are a major target group for energy assistance. They spend, on average, a greater portion of their income for heating costs than other low-income households. Grantees are required to target outreach activities to elderly or handicapped households eligible for energy assistance. In their crisis intervention programs, grantees must provide physically infirm individuals the means to apply for assistance without leaving their homes, or the means to travel to sites where applications are accepted.

In fiscal year 2001, about 34 percent of households receiving assistance with heating costs included at least one person age 60 or over, as estimated by the March 2001 Current Population Survey.

OCS is a member of the National Energy and Aging Consortium, which focuses on helping older Americans cope with the impact of high energy costs and related energy concerns.

The 1998 reauthorization retains legislation from the 1994 reauthorization that specifically allows grantees to target funds to vulnerable populations, mentioning by name "frail older individuals" and "individual with disabilities." No new initiatives commenced in fiscal years 2001 or 2002 that impacted on the status of older Americans.

THE COMMUNITY SERVICES BLOCK GRANT (CSBG) AND THE ELDERLY

The Community Services Block Grant (CSBG) is a Department of Health and Human Services block grant program administered by the Office of Community Services (OCS) in the Administration for Children and Families (ACF).

The Community Service Block Grant Act is authorized by the Omnibus Budget Reconciliation Act of 1981, as amended, (Public Law 97-35), and the Coats Human Services Reauthorization Act of 1998 (Public Law 105-285). The Community Services Block Grant (CSBG) is provided to States, Tribes and Territories[4] to provide services and activities to reduce poverty, including services to address employment, education, and better use of available income, housing assistance, nutrition, energy, emergency services, health and substance abuse needs. The CSBG act mandates that states pass 90 percent of the block grant through to local entities, retaining up to 5 percent for administrative costs and up to 5 percent for other costs and/or technical assistance. CSBG services are administered primarily through a network of private, non-profit entities called community action agencies (CAAs) in coordination with other neighborhood-based organizations. CAAs were created by the original legislation that authorized the programs that became the Community Services Block Grant, and they provide services to more than 90 percent of the nation's communities.

Each state submits to the Department of Health and Human Services an annual application, and certification that the State agrees to hold the CSBG network accountable in providing (1.) a range of services and activities having a measurable and potentially major impact on the causes of poverty in communities where poverty is an acute problem and (2.) activities designed to assist low-income participants, including the elderly, to become self-sufficient.

As a result of the statutory requirements, the CSBG Task Force on Monitoring and Assessment, a representative body of community organizations that administer CSBG, state and Federal partners, established a goal of service provision which states, "Low-income people, especially vulnerable populations, achieve their potential by strengthening family and other support systems." This goal assists local, state and federal agencies to focus jointly on vulnerable populations, particularly the frail elderly.

Of the approximately 13 million poor individuals served with CSBG funds in Fiscal Year 2001 (the latest year for which data are available), 16 percent, or 1.4 million individuals were considered older adults meaning they were 55 years of age or older. More than half of the 1.4 million were 70 years of age or older. The older American population served by the CSBG network received services that will help them primarily to maintain independence including transportation, adult day care programs, nutritional assistance, weatherization, home repair, and social

[4] Hereafter, States, Tribes and Tribal organizations are referenced collectively as States.

or recreational programming.

Funding levels under the CSBG program for States and Indian Tribes and Territories for FY 2001 amounted to $586.7 million for the States and Territories, and $3.7 million for the Tribes. For fiscal year 2002, $635.9 million was allocated for the States and Territories, and $3.8 million for the Tribes.

AGING AND DEVELOPMENTAL DISABILITIES PROGRAMS

The Administration on Developmental Disabilities (ADD) is the U.S. Government organization responsible for implementation of the Developmental Disabilities Assistance and Bill of Rights Act of 2000, known as the DD Act. ADD, its staff and programs, are part of the Administration for Children and Families, of the U.S. Department of Health and Human Services.

Developmental Disabilities are physical or mental impairments that begin before age 22, and alter or substantially inhibit a person's capacity to do at least three of the following (1.) Take care of themselves (dress, bathe, eat, and other daily tasks); (2.) Speak and be understood clearly; (3.) Learn; (4.) Walk/move around; (5.) Live on their own; or (6.)Make decisions.

The DD Act requires ADD to ensure that people with developmental disabilities and their families receive the services and supports they need and participate in the planning and designing of those services. The DD Act established eight areas of emphasis for ADD programs; Employment, Education, Child Care, Health, Housing, Transportation, Recreation, and Quality Assurance. ADD meets the requirements of the DD Act through the work of its four programs.

The Administration on Development Disabilities (ADD) supports a number of projects on aging through grant funds to:

- State Councils on Developmental Disabilities
- University Centers for Excellence in Developmental Disabilities Education, Research and Services, and
- Projects of National Significance.

It is through these entities that ADD has advanced work around aging, described in detail in the following pages.

State Councils on Developmental Disabilities

Each state has a Developmental Disabilities Council that functions to increase the independence, productivity, inclusion, and community integration of people with developmental disabilities. DDC activities demonstrate new ideas for enhancing people's lives through training activities, through community education and support, by making information available to policy-makers, and by eliminating barriers.

2002 Conference on Aging
The Oklahoma Developmental Disabilities Council Phone: 405-521-4984 Fax: 405-521-4910
http://www.okddc.org/
Through efforts of the Council and its sibling organizations, many advocates trained through Partners in Policymaking and other like programs have been appointed to state boards and commissions.
Direct Support Professional Recruitment Campaign
Vanessa Smith, MSW & Project Program Specialist Phone: 501-526-5965 Fax: 501-526-5961
The DSP Recruitment Campaign was a statewide recruitment effort for workers in the field of developmental disabilities and in the aging community. The recruitment campaign materials consist of a commercial counter cards, buttons, website (www.2BEaDSP.com), and a database to collect information.

University Centers for Excellence in Developmental Disabilities Education, Research and Services (UCEDD)

UCEDD is a grant program providing support to a national network of University Centers to support interdisciplinary training, exemplary services, technical assistance, and information/ dissemination activities. University Centers positively affect the lives of individuals with developmental disabilities and their families by increasing their independence, productivity, and integration into communities. University Centers have four broad tasks: conduct interdisciplinary training, promote community service programs, provide technical assistance at all levels (from local service delivery to community and state governments), and conduct research and dissemination activities.

Illinois Center on Health Promotion, Nutrition, Physical Activity and Disability, University of Illinois at Chicago

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Website: http://www.ncpad.org/

There is a clear consensus among experts in the field that nutrition is a key element in optimal health and that poor nutrition is a serious public health concern. People with disabilities are likely to be at greater risk that the general population for developing secondary health conditions due to sedentary lifestyles and poor nutrition. A major barrier is the fact that many health professionals currently do not associate terms such as wellness, exercise, and health promotion with persons with disabilities. The situation is exacerbated by the fact that the scientific and practical information that does exist is poorly organized and spread throughout a wide range of publications, from scientific journals to the popular press and 'informational materials' from manufacturers themselves. As a result, consumers, practitioners, and researchers, seeking information on health, nutrition and exercise for persons with disabilities have great difficulty finding the resources they require.

The Illinois Center on Health Promotion, Nutrition and Disability will build upon the substantial structure of the National Center on Physical Activity and Disability (NCPAD) to create an electronic information center on health and nutrition for persons with disabilities, including the elderly and chronic conditions, such as osteoarthritis, diabetes, and osteoporosis.

University of South Carolina -
Center for Disability Resources

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Fax: 803-935-5250

Website: www.cdd.sc.edu/

The Attendant Care Project is dedicated to offering personal choice options to consumers of attendant care services. The program serves people who are eligible for services under the Elderly and Disabled Medicaid Waiver, the HIV/AIDS Medicaid Waiver and the Head and Spinal Cord Injury (HASCI) Medicaid Waiver. USCCEDD Nurse Consultants work with consumers to facilitate the recruitment and to match the consumer with an attendant. The Nurse observes the attendant providing attendant care services to ensure the attendant understands what is needed and is capable of providing the services. An additional part of this process is the recruitment of attendants into the Medicaid provider program. Once enrolled, the attendants are self-employed individuals who are paid directly from Medicaid.

Staff provide training to consumers and to the attendants. The project serves approximately 800 consumers annually and trains approximately 300 attendants.

System Change: This project promotes consumer choice within the state's system-driven long-term care system. It enables consumers to choose their provider and determine the schedule for services according to their needs rather than have both decided by a PCA agency or service coordinator. This project is providing the foundation for SC DHHS's expansion to a consumer-directed home and community based waiver through it's Real Choice grant.

Multicenter Trial of Vitamin E for Aging Persons with Down Syndrome

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The goal of this project is to determine whether high dose vitamin E, which has been shown to delay the progression of Alzheimer's disease, will slow the rate of cognitive/functional decline in older individuals with Down syndrome. Individuals with Down syndrome 50 years of age or older, with or without a diagnosis of Alzheimer's disease, are eligible for enrollment. A total of 400 persons functioning at all levels of mental retardation will be enrolled at approximately 20 sites. A vitamin E regimen (1,000 international units twice daily, plus a multivitamin) will be compared to a multivitamin alone in a two-arm parallel group design. The treatment period is three years, with study visits at six-month intervals. The primary outcome measure is a brief test of praxis, measuring cognitive functions expressed as performance of simple, short sequences of voluntary movements. This will be the first large-scale treatment study of Alzheimer's disease complicating Down syndrome. It will serve as a model for future efforts at applying treatments developed for sporadic Alzheimer's disease to the population of at-risk individuals with Down syndrome.

Funding: WIHD is one of several international sites participating in this study which is funded by a grant to the Institute for Basic Research from the the National Institutes of Health, from September 2001 through August, 2004.

Projects of National Significance

Under Part E of the Developmental Disabilities and Bill of Rights Act of 2000, ADD awards grants and contracts for Projects of National Significance (PNS) to enhance the independence, productivity, integration, and inclusion of individuals with developmental disabilities and their families. Projects promote promising practices, provide technical assistance, collect data, educate policy makers, and expand opportunities for individual with disabilities to participate in decision making.

The activities of PNS grantees often impact the life of aging parents with adult children who have disabilities as well as individuals with developmental disabilities who are aging. Examples of such projects can be found in ADD's "Last Passages" and "Supporting Elderly Families."

Supporting Elderly Families Caring for Sons and Daughters with Disabilities at Home at Community Support Network, Inc.
Francis J. Haines jhaines@cnsi.org Phone: (613) 229-1982 Fax: (613) 223-2377
This project proposes to continue to further its initiative to strengthen and expand the family support system. The project will support elderly family members with resource information to share with one another and assist with personal future planning, guardianship, wills, trusts, and other personal future planning. It will provide respite care services and provide service coordinators with unique knowledge about people who are elderly that need help locating various services.
Family NET Works at Maryland Council on Developmental Disabilities
Denise Marshall director@family-networks.org Phone: (410) 333-0454 Fax: (410) 333-3686 FAX
This project proposes to establish a Family Advisory Council to advise and assist with implementation, evaluation, and recommendations. It will focus on policy development and creation of action plans to provide an interactive, family-friendly website. Focus will be on empowerment zones, foster/adoptive families, and children with special needs. This array of information will link to essential resources and supports; and plans are to reach out to unserved families, especially those of cultural or linguistic diversity and aging caregivers.

Family Leadership and Family Support System Change at Illinois Department of Human Services

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This project will address the need for systems change and continual development of a strong advocacy group of families and support of a statewide collaborative Task Force that provides guidance to these groups. There will be further development efforts to increase participation of minority families and aging family caregivers through outreach and educational activities. Specific goals are to conduct an ongoing assessment of policies and develop a strong family leadership initiative through training and technical assistance. The project will also provide technical assistance to new and ongoing initiatives through an active Family Support Task Force; develop an outreach and training demonstration project for unserved and underserved groups, including minority caregivers and aging caregivers; and disseminate results of this project in Illinois and nationally.

Double Jeopardy at Ohio State Department of Aging

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Fax: (614) 466-0298

This is a multi-agency collaboration to support older families who have sons and daughters with developmental disabilities. Plans for this project are to secure future services for persons with a disability as well as the aging parent. These agencies will jointly plan and implement this program at the state and local levels. Activities will include cross-training; training on estate planning for attorneys and other professionals; training of family members, including those with mr/dd; and outreach to and education of known and hidden families. The project will utilize lessons learned from Phase I and evaluate all training sessions and do a needs assessment/policy study on factors that affect family motivation. Products of this program will include a revised curriculum package, a media/promotional packet, and written reports of activities and materials that can be replicated nationally.

Idaho Family Support Project at University of Idaho, Center on Disabilities and Human Development

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Phone: (208) 885-3559
Fax: (208) 885-3628

This project proposes to enhance and increase support to aging families and families living in rural and remote communities. Project objectives are: Establish a state policy council to implement project goals; develop policy to strengthen support systems; provide training to ensure consistent delivery of services to all families; incorporate a statewide philosophy of family support; and develop innovative partnerships.

Family Friends Project at The National Council on the Aging

Miriam Charnow
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Fax: (202) 479-0735

The project proposes to design, implement, and evaluate program models that test the feasibility and value of using older adult volunteers as part of a services support network for aging parents of adult children with disabilities. It will explore ways to involve volunteers assisting families, identify promising approaches, and disseminate this information among those with disabilities in the community. This organization will develop a pilot project to test the possibilities of refining or reforming state services for elderly parents with aging children who have developmental disabilities.

Last Passages: Planning for the End of Life for People with Developmental Disabilities at Volunteers of America, Inc.

Angela King
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Fax: (817) 719-8897

This project is collaborating with other organizations to disseminate a successful model for improving end of life planning and care for individuals with developmental disabilities. Training and support are provided through a website, networking, and national conferences. Persons with disabilities, health providers, advocates, and family members have identified a need for this information, training, and support as a priority. A number of public and private organizations joined together to develop the model for end-of-life care and produce a handbook on support resources.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY ACTIVITIES FOR CALENDAR YEARS 2001 AND 2002 ON BEHALF OF OLDER AMERICANS

Introduction

The Agency for Healthcare Research and Quality (AHRQ) promotes health care quality improvement by conducting and supporting health services research that develops and presents scientific evidence regarding all aspects of health care. Health services research addresses issues of "organization, delivery, financing, utilization, patient and provider behavior, quality, outcomes, effectiveness and cost. It evaluates both clinical services and the systems in which these services are provided. It provides information about the costs of care, as well as its effectiveness, outcomes, efficiency, and quality. It includes studies of the structure, process, and effects of health services for individuals and populations. It addresses both basic and applied research questions, including fundamental aspects of both individual and systems behavior and the application of interventions in practice settings."[1]

The Agency uses mechanisms of grants, cooperative agreements, intramural research and contracts to carry out research projects, demonstrations, evaluations, and dissemination activities. AHRQ also supports conference grants, and training through dissertation grants and National Research Service Awards to institutions and individuals.

Since its inception, AHRQ (formerly the Agency for Health Care Policy and Research), has engaged in, supported, and disseminated aging-specific health services research. The Agency's reauthorization legislation, P.L. 106-129, the Healthcare Research and Quality Act of 1999, mandated the creation of an Office of Priority Populations to continue and build the research and associated activities that AHRQ undertakes on behalf of priority populations. The elderly, the disabled and those near the end of life are all among the Agency's mandated priority populations.

The agency fosters research on clinical, organizational, and system factors that affect the delivery of care to the elderly and help inform policy makers on how to improve the health care system. Caring for older persons involves clinical complexities that are difficult for families, clinicians, health plans, and purchasers to address. Care often involves the coordination of an array of preventive, acute, chronic, rehabilitative, and long term care services. Also the financing of care for older persons remains fragmented and incentives are often conflicting.

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[1] Eisenberg JM. Health Services Research in a Market-Oriented Health Care System. *Health Affairs*, Vol. 17, No. 1:98-108, 1998.

To accomplish the Agency's mission, AHRQ has identified strategic goals that contribute to improving the quality of health care for all Americans, including America's seniors. These goals include, improving:

- Health care outcomes
- Health care quality
- Health care safety
- Access, use and expenditures, and
- Information available to consumers and decisionmakers.

This report divides the Agency activities by these goals and provides illustrative examples of activities during 2001-2002 that are particularly important to older Americans. The final section of the report is an Appendix that contains abstracts of projects funded during 2001 and 2002 and a bibliography of articles resulting from AHRQ-supported studies that were published during this period.

Health Care Outcomes

Outcomes and effectiveness research seeks to understand the end results of particular health care practices and interventions. Outcomes include effects that people experience and care about, such as changes in the ability to function. In particular, for individuals with chronic conditions—where cure is not always possible—end results include quality of life as well as mortality. By linking the care people get to the outcomes they experience, outcomes research has become the key to developing better ways to monitor and improve the quality of care.

Examples of Older American activities:

Chronic Disease Self-management Program (CDSMP): Adherance to medication regimens and maintaining functional ability are outcomes common to many seniors. AHRQ-funded research conducted by the Stanford University Patient Education Research Center found that the CDSMP can help prevent or delay disability, even in patients with heart disease, hypertension or arthritis. The CDSMP is a 17-hour course taught by trained lay people that teaches patients with chronic disease how to better manage their symptoms, adhere to medication regimens and maintain their functional ability.

Comprehensive Outcomes of Frail Elders in the Community: The goal of this research is to identify the determinants of comprehensive health outcomes (mortality, functional change, hospitalization, and quality of life) in frail nursing home eligible patients who continue to live in the community. Subjects are patients at 12 national sites of the Program of All-Inclusive Care For the Elderly (PACE), a rapidly expanding program that cares for patients in the community that have been certified as eligible for nursing homes. The products of this research are a critical first step in developing methods to measure variations in outcomes and the quality of care, developing interventions to improve care of frail elders, and assessing the effectiveness of the rapidly growing PACE program.

Program of Collaborative Care for Alzheimer Disease: This research project is designed to test the efficacy of an Integrated Program of Collaborative Care as compared to usual care in improving the outcomes of care for older adults with Alzheimer Disease in a primary care setting. Although guidelines for the care of patients with Alzheimer Disease and related disorders have been published, there are no clinical trials that test the impact of close adherence to these guidelines on the outcomes of care for a group of vulnerable older adults in an urban primary care setting. The study exams the prevalence of dementing disorders and associated comorbidity in primary care and measures utilization, costs, use of community services, and the costs associated with the intervention.

US Preventive Services Task Force (USPSTF): The Centers for Medicare and Medicaid Services (CMS) is using USPSTF recommendations based on AHRQ-sponsored systematic evidence reviews to develop messages (based on focus group testing) for consumers and clinicians regarding Medicare-covered services for osteoporosis, cervical cancer, prostate cancer and breast cancer. In September, 2001 the USPSTF recommended that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.

Centers for Education and Research on Therapeutics (CERTS): The mission of the CERTs is to conduct research and provide education that will advance the optimal use of drugs, medical devices, and biological products. Many of these projects are concerned with medications and medical devices that are often used by the elderly.

Health Care Quality

One of AHRQ's strategic goals is to improve health care quality measurement and track and promote improvements in the care available to Americans. To achieve this goal AHRQ has invested in the development and testing of measures of quality, as well as studies of the best ways to collect, compare and communicate these data, and identifying and widely disseminating effective strategies to improve quality of care. To facilitate the use of this information in the health care system, the Agency focuses on research that determines the most effective ways to improve health care quality, including promoting the use of information on quality through a variety of strategies such as information dissemination and assessing the impact of health care organization and financing on health care quality.

Examples of Older American activities:

AHRQ Quality Indicators: Health care decisionmakers need user-friendly data and tools to help them assess the effects of health care programs and policy changes, accurately measure outcomes, community access to care, utilization and cost of care. To meet this need, AHRQ has developed a set of quality indicators (QIs) that use hospital administrative data to highlight potential quality concerns, identify areas that need further

study and investigation, and track changes over time. These indicators represent a refinement and further development of the Quality Indicators developed in the early 1990's as part of the Healthcare Cost and Utilization Project (HCUP). The AHRQ QIs are a set of quality indicators that have been organized into three modules: Prevention, Inpatient, and Patient Safety QIs.

Partnerships for Quality: A coordinated set of projects, that develop partnerships among researchers, health plans, medical and nursing facilities and services, employers, consumer groups and professional societies, including the American Medical Association and the Leapfrog Group, to test prototype activities aimed at accelerating the health system's adoption of research findings that have been shown to improve quality of care for patients. The projects span much of the nation and involve more than 88,000 medical providers, 5,800 hospitals, nursing homes and other health care facilities; and 180 health plans. Projects of particular relevance to older Americans include implementing quality improvement strategies in long-term care facilities; and testing learning collaborativea for quality improvement in home health care settings.

Translating Research Into Practice (TRIP): The purpose of AHRQ's TRIP initiative is to generate new knowledge about approaches that promote the utilization of rigorously derived evidence to improve patient care. The Agency's goal is to enhance the use of research findings, tools, and scientific information that would work in diverse practice settings, among diverse populations, and under diverse payment systems. Examples with particular importance to seniors are:

- *Improving Pain Management in Nursing Homes*: Develops and implements a culturally competent, evidence-based educational and behavioral intervention to improve the quality of pain assessment and management in two nursing homes. Influence and changes of organizational variables and cost-effectiveness of the intervention to nursing homes will be assessed.
- *A Model for Use of the Urinary Incontinence Guideline in U.S. Nursing Homes*: Tests the effectiveness of a model of care implemented by nurse practitioners in collaboration with nurses and physicians to translate the AHRQ Urinary Incontinence Guideline into practice in 10 New York nursing homes.
- *Optimizing Antibiotic Use in Long-Term Care*: Assesses whether an evidence-based clinical algorithm for managing urinary tract infections in older adults in residential long-term care facilities (LTCFs) can reduce the overall use of antibiotics in LTCFs.
- *Primary and Secondary Prevention of Coronary Heart Disease and Stroke*: Evaluates the impact of a quality improvement model using academic detailing and electronic medical records on adherence with clinical practice guidelines for prevention of cardiovascular disease and stroke in 22 primary care settings across the United States.
- *Evidence-based 'Reminders' in Home Health Care*: Investigates providers' use of evidence-based guidelines in the treatment of two highly prevalent chronic

diseases—congestive heart failure and cancer—and how the use of guidelines affects quality and cost of care.

- *Reducing Adverse Drug Events in the Nursing Home*: Tests whether a computer-based clinical decision-support system can lower the rate of adverse drug events and potential adverse drug events in nursing homes.

Health Care Safety

AHRQ's reauthorizing legislation, signed into law on December 6, 1999, gave the Agency the mission of establishing a comprehensive Patient Safety Initiative. AHRQ conducts and supports research and builds private-public partnerships to: Identify the causes of preventable health care errors and patient injury in health care delivery; Develop, demonstrate, and evaluate strategies for reducing errors and improving patient safety; and Disseminate such effective strategies throughout the health care industry.

AHRQ's safety research portfolio addresses questions such as when, how and under what circumstances errors occur; how to develop the tools, data, and training to answer future questions; how to work with public and private partners to apply evidence-based approaches to the improvement of patient safety; and how to monitor and evaluate threats to patient safety.

Examples of Older American activities:

- *Working Conditions*: Several projects examine the effect of working conditions on health care workers' ability to provide safe, high-quality care in ambulatory, inpatient (both hospital and long term care institutions) and in home care settings.
- *Reducing Errors in Long-Term Care*: Several projects evaluate the effects of clinical information systems on reducing errors and predicting risks of adverse outcomes for patients in nursing home and home health care.
- *Potentially Inappropriate Medications*: A number of studies assess the prevalence of and risk factors for potentially inappropriate drugs for elderly living in the community and long term care settings.
- *The Falls Management Program*: The Falls Management Program is a quality improvement program designed to help staff in nursing facilities reduce falls and related injuries, and is based on interventions previously tested in long-term care facilities.
- *Hospital-acquired Incontinence*: This study estimates the incidence of, and identifies risk factors for hospital-acquired incontinence in female elderly hip fracture patients.
- *Hospital Volume and Surgical Mortality Among Medicare Beneficiaries*: This study shows that in the absence of other information about the quality of surgery at the hospitals near them, Medicare patients undergoing selected cardiovascular

or cancer procedures can significantly reduce their risk of operative death by selecting a high-volume hospital.

Access, Use, and Expenditures

The Agency addresses critical research and policy issues pertaining to the access, use, and cost of health care. Of special concern are the Agency's priority populations including the elderly. The agency sponsors the Medical Expenditure Panel Survey (MEPS), among other activities, to monitor changes in access, use, and expenditures for persons of all ages.

Examples of Older American activities:

Access to Medicare Hospice Services: This study measures the effects of nursing homes, hospice providers and market characteristics on the availability of hospice in nursing homes, and measures the effects of patient nursing home and hospice provider characteristics on the election of the Medicare hospice benefit by eligible nursing home patients.

Urban –Rural Differences: Elders in rural areas use nursing homes at a higher rate than elders in non-rural areas. This study examines the differences between home care and nursing home users within urban/rural boundaries and determines how differences in community resources influence access to long-term care services.

Out-of-Pocket Burden: This study assesses the burden of out-of-pocket spending for prescription drugs in elderly female Medicare Beneficiaries. It looks at the trends in out-of-pocket burden from 1992 to 1998 and whether there was a change in predictors of high burden during this period.

Medical Expenditure Panel Survey: MEPS is designed to provide policymakers, health care administrators, businesses, and others with timely, comprehensive information about health care use and costs in the United States and to improve the accuracy of their economic projections. Moreover, MEPS is the only national survey that provides a foundation for estimating the impact of changes in sources of payment and insurance coverage on different economic groups or special populations of interest, such as the poor, elderly, families, veterans, the uninsured, and racial and ethnic minorities and thus permits analysis at the family- and the person-level, comparing the elderly and non-elderly. See http://www.ahrq.gov/data/mepsix.htm for the MEPS bibliography of projects.

Efforts to Improve Measurement of Use and Expenditures for Persons Needing Long Term Care:

- *Inventory of Long-Term Care Residential Places*: This joint project with NCHS and ASPE is the first step in the development a sample frame for assisted living facilities. This would provide a foundation for the expansion of NCHS provider-based surveys to include assisted living facilities, the fastest growing segment in

the long-term care. Currently no national information is available about this segment of the long-term care market.

- Development of an instrument, that could potentially be used in the MEPS, to measure the cost of informal caregiving provided by those that live with a person needing or using long-term care services.

- Using the MEPS institutional component data from 1996, during the 2001-20002 period, AHRQ developed a national prescription drug file that can be useful to assess a broad set of issues related to drug prescribing in nursing homes. This file enables studies of drug complications as well as outcome studies to determine the benefits and negative impacts of prescribing practices in nursing homes.

- Collaborate with others in the Department of Health and Human Services enhance existing data systems to improve the measurement of the long-term care population. Efforts in this area have included collaboration with NCHS on the enhancements to the National Nursing Home Survey, work with ASPE and NCHS on the development of new data collection measures specific to the long–term care work force and use of assisted technologies, and efforts with the Centers for Medicare and Medicaid Services in support of Aging Forum activities.

Improve Information Available to Consumers and Decisionmakers

One of the AHRQ's most important priorities is to translate and disseminate the findings of research supported by the Agency into tools and information that can be used by its customers to make good health care decisions and to improve the outcomes of care. Americans are demanding greater value and quality in their health care. To achieve these goals in today's rapidly changing health care environment, consumers need solid, reliable information to help them choose among health care plans, practitioners and facilities, and to participate more actively in their personal health care decisions. AHRQ plays a unique role in helping to provide the information consumers need and want by fostering translation and dissemination of new knowledge into practice by developing and providing information, products, and tools on outcomes; quality; and access, cost, and use of care.

Examples of Older American activities:

Consumer Assessments of Health Care: CAHPS® (formerly the Consumer Assessment of Health Plans Study) has become an industry standard for obtaining and reporting consumers assessments of their care to help consumers choose a health plan. CAHPS® was developed with AHRQ grant support to a consortia headed by Harvard Medical School, Research Triangle Institute, and RAND. CAHPS® surveys are being used by the Medicare Program, more than 20 State Medicaid and SCHIP agencies, employer groups and business coalitions, the Federal Employees Health Benefits Program, Department of Defense, and a wide range of health plans. In 2002, over 123 million Americans had

access to CAHPS® data to help them choose a health plan, including 39 million Medicare beneficiaries and 9 million Federal employees, retirees, and their family members covered under the Federal Employees Health Benefits Program.

Originally designed for measurement at the health plan level, CAHPS® has expanded to other health care settings and specific populations such as the group provider level, behavioral health services and children with chronic conditions. In addition to the three CAHPS® surveys already implemented in the Medicare program (Managed Care, Fee-for Service, and Disenrollment), two additional surveys are being developed that would be relevant to an aging population:

- *CAHPS® for People with Mobility Impairments Project:* A partnership among AHRQ, NIDRR, and CDC to develop a CAHPS® to assess care experiences of people with mobility impairments was initiated in 2002.

- *Nursing Home CAHPS®*: The purpose of NH-CAHPS® is to test and design a satisfaction instrument for care provided to residents of nursing homes. The survey attempts to capture information on beneficiary experience concerning the quality of health care and activities of daily living (ADL)/personal care services provided to residents in nursing homes. There were several rounds of cognitive testing and revisions of the resident instrument during 2001-2002.

The National Guideline Clearinghouse™ is a public on-line resource for evidence-based clinical practice guidelines. NGC is sponsored by the Agency for Healthcare Research and Quality in partnership with the American Medical Association and the American Association of Health Plans. The database is continually updated and includes over 200 Guidelines relevant to the elderly. Examples included or updated during the 2001-2002 include: Elderly suicide: secondary prevention; oral hygiene care for functionally dependent and cognitively impaired older adults; practice management guidelines for geriatric trauma; prevention and management of hip fracture in older people; and screening for cognitive impairment and dementia in the elderly (http://www.guideline.gov).

Talking Quality: AHRQ along with CMS, and the U.S. Office of Personnel Management (OPM) officially launched a new Government Web site designed to help benefit managers, consumer advocates, and State officials communicate with their audiences about health care quality. The site, http://www.TalkingQuality.gov, provides step-by-step instructions on how to implement a quality measurement and reporting project such as a health plan report card.

Medicare Beneficiaries' Perceptions and Knowlegde: Research efforts related to Medicare beneficiaries and their understanding of the Medicare program have also received AHRQ extramural support. This work has included: Measuring beneficiary knowledge in two randomized experiments, beneficiaries' perceptions of new Medicare health plan choice print materials, and beneficiary survey-based feedback on new Medicare informational materials.

Evidence-based Practice Centers: In June 2002 AHRQ funded 13 Evidence-based Practice Centers (EPCs). Their mission is to promote evidence-based practice in everyday health care by facilitating the translation of evidence-based research findings into practice. Recent evidence reports with particular relevance to elders include: Telemedicine for the Medicare population (2001), osteoporosis in postmenopausal women: diagnosis and monitoring (2001), management of cancer pain (2001), utility of blood pressure monitoring outside of the clinic setting (2002), management of cancer symptoms: pain, depression, and fatigue (2002), and measures of patient safety based on hospital administrative data—the patient safety indicators (2002). http://www.ahrq.gov/clinic/epc

Dissemination to State and Local Lawmakers: AHRQ's User Liaison Program (ULP) disseminates health services research findings in easily understandable and usable formats through interactive workshops that are planned to meet the needs of State, local and Federal policymakers (http://www.ahrq.gov/news/ulpix.htm). Recent national workshops that focused on concerns of the elderly included:

- Building a High-Quality Long-term Care Paraprofessional Workforce, Dallas, Texas, February 7-9, 2001
- Beyond Olmstead: Community-Based Services for All People with Disabilities, Chicago, IL, July 11-13, 2001
- State Long-term Care Programs: Balancing Cost, Quality, and Access, Indianapolis, Indiana, May 6-8, 2002.
- Managing Care for Adults with Chronic Conditions, co-sponsored by AHRQ and CMS, Philadelphia, PA, December 11-13, 2002.

Grant Number: R03 HS10813
PI Name: APARASU, RAJENDER
Project Title: EVALUATION OF INAPPROPRIATE PSYCHOTROPIC USE IN ELDERLY
Abstract: Inappropriate medication use in the elderly population is a significant public health concern in light of their many potentially deleterious outcomes. Recent studies by the investigators indicated that one in twenty prescriptions for the elderly in ambulatory settings involved inappropriate medications, of which inappropriate psychotropic agents constituted a major portion. Using the Medical Expenditure Panel Survey (MEPS), this research will evaluate inappropriate psychotropic use by the community elderly in the United States based on the criteria defined in the clinical literature. Specific objectives of this research are: (1) to characterize community elderly using psychotropic medications in the United States, (2) to describe the nature and extent of inappropriate psychotropic use in this population, (3) to examine the factors associated with inappropriate psychotropic medication use, and (4) to assess the impact of inappropriate psychotropic use on health care utilization and costs. This study involves analyses of medical and utilization data of the cohort of persons 65 years of age or older using psychotropic use, and multivariate analyses will be applied to evaluate the associated factors and impact of inappropriate psychotropic use. This investigation will provide valuable information to health care providers and policy makers so as to the extent of the problem, elderly-at risk, and the resultant impact of inappropriate psychotropic use on the health care system. In addition, this research will be instrumental in optimizing pharmaceutical care provided to the elderly.
Fiscal Year: 2000
Department: SOUTH DAKOTA STATE UNIVERSITY
Project Start: 09/01/2000 - **Project End:** 08/31/2003

Grant Number: R03 HS11606
PI Name: BORDERS, TYRONE
Project Title: HISPANIC AND RURAL ELDERS' SATISFACTION WITH HEALTH CARE
Abstract: Ratings of satisfaction with the accessibility and quality of health services are useful indicators of community health system performance. Satisfaction ratings offer health system managers, health policy makers, and clinicians insight about consumers' expectations and experiences with health care providers and organizations. Such information can be used to improve the organization, financing, and delivery of health services.

Of particular concern is the potential inadequate accessibility and quality of medical care provided to elderly rural residents and Hispanic Americans, two historically vulnerable populations. Unfortunately, relatively few population-based studies of satisfaction with health care accessibility and quality have included both rural and urban Hispanics. Even fewer studies have focused on elders' satisfaction with accessibility and quality. Moreover, there may be regional variation in satisfaction. The purpose of the proposed study is to help close the gap in our understanding of rural/urban and ethnic differences in elderly persons' satisfaction with the accessibility and quality of their health care. It would be conducted in a region with a relatively high percentage of rural residents and persons of Mexican descent. The study sample will be based on participants in a health services research survey of elderly persons (the Texas Tech 5000 survey). Andersen and Aday's behavioral model of health services will be employed to explain how health system, predisposing, enabling, and need factors are associated with perceptions of accessibility and quality. Accessibility and quality will be assessed using measures from the Consumer Assessment of Health Plans Study (CAHPS) questionnaire.
Fiscal Year: 2001
Department: TEXAS TECH UNIVERSITY HEALTH SCIS CENTER
Project Start: 09/01/2001
Project End: 11/30/2002

Grant Number: R01 HS10645
PI Name: BUCHANAN, JOAN
Project Title: HOSPITALIZATION OF NURSING FACILITY RESIDENTS
Abstract: Nursing facility (NF) residents, typically suffer from a constellation of chronic illnesses that leave them frail and vulnerable. For these individuals, hospital care may be necessary to cure serious acute illness, manage clinically complex chronic care, and restore lost function. However, it can also be disruptive and escalate functional decline. Data from NMES indicate that hospitalization rates among NF residents are notably higher than for the elderly as a whole. Further, a recent study found that nearly half of all hospitalization for NF residents was inappropriate. Both the costs and the clinical implications for this population, point to the need for a more comprehensive evaluation of factors contributing to variations in practice style and unnecessary hospitalization.
This project will develop a comprehensive model of the determinants of NF hospitalization rates that includes economic and environmental incentives, NF and resident characteristics, and differentiates types of hospitalization. Because many studies point to the need for greater medical attention within NFs, we also include a set of variables labeled physician-NF interaction that describe NF practices that might increase physician presence within NFs. We use an expert panel of practicing geriatricians to distinguish hospitalizations that are unavoidable from those that either could have been prevented or involved considerable discretion in the decision to hospitalize. The clinical capabilities available within a NF may influence these classifications.
Data for the study come from two existing (Minimum Data Set (MDS)) databases on NF residents (from 1992-1995, and 2001-2002) which will be linked to Medicare hospital claims data. These will be supplemented by surveys of NF Medical Directors and Directors of Nursing to obtain information on policies and procedures surrounding, the hospitalization of residents, the availability of clinical resources and physicians within the facility, and staff attitudes towards hospitalization. NF characteristics from the Medicare's facility certification files and local area resources (from HCFA's area resource file) will be appended to the two databases.

We will also develop a (case-mix adjusted) NF profile of hospital use to monitor hospitalization rates and potentially quality of care. The validity of our profiling tool will be assessed through comparison with other NF quality indicators (from the MDS) thought to be related to hospitalization and by an analysis of mortality rates.
Fiscal Year: 2000
Department: HARVARD UNIVERSITY (SCH OF PUBLIC HLTH)
Project Start: 09/30/2000 - **Project End:** 09/29/2004

Grant Number: U18 HS13699
PI Name: BRODERICK, SUZANNE
Project Title: Different Approaches to Information Dissemination
Abstract: Proposed is a four-year project aimed at dissemination of evidence-based practices in nursing homes and adult care facilities through provision of training modules. The New York State Department of Health (NYSDOH) is joining in partnership with the Research Division of the Hebrew Home for the Aged (RDHHAR), with representatives of the Columbia University Stroud Center and with two national organizations representing nursing homes and adult care facilities (board and care homes), and the state government inspectors responsible for surveillance and quality assurance in these facilities: the American Health Care Association (AHCA) and the Association of Health Facilities Survey Agencies (AHFSA). Finally, representatives from the Foundation for Long-Term Care (FLTC), the research arm of the New York Association of Homes and Services for the Aging (LNYAHSA), a recipient of an AHRQ grant to further develop quality indicators in long-term care, will provide consultation. Representatives from these institutions will form a multi-disciplinary Advisory Group to: (a) identify effective training modules, based on findings from studies completed and published by the NYSDOH Dementia Grants program, AHRQ-funded studies, and from the Columbia University New York State Psychiatric Institute (NYSPI) and the Columbia University Geriatric Education Centers (GEC) training programs; (b) evaluate the methods for

dissemination of best practices guidelines, including a program to train surveyors in best practice; and (c) disseminate the programs to the facilities that, collectively, are representative of a target population of several million individuals with chronic health and mental disorders.
Fiscal Year: 2002
Department: NEW YORK STATE DEPT OF HEALTH
Project Start: 09/30/2002 - **Project End:** 09/29/2006

Grant Number: R01 HS10884
PI Name: CALLAHAN, CHRISTOPHER
Project Title: A PROGRAM OF COLLABORATIVE CARE FOR ALZHEIMER DISEASE
Abstract: Alzheimer Disease and related disorders are common among older adults attending primary care clinics. Unfortunately, many of these vulnerable older adults do not receive an adequate diagnosis, evaluation, education, treatment, or long-term management. Also, primary care practices are rarely designed to provide education and support for the caregivers of patients with dementia. Fragmentation of care within the health care system and poor communication among the health care providers and between local social support agencies contribute to frustration, poorer outcomes, and increased costs. Indeed, primary care practitioners appear to have tremendous difficulty in delivering a systematic program of care for older adults with dementia. In our earlier studies, we found that nearly 1 in 6 patients over the age 60 attending a large primary care practice suffered from cognitive impairment. Unfortunately, 75% of the patients with moderate to severe cognitive impairment had not been diagnosed with a dementing disorder. Patients with moderate to severe cognitive impairment were more likely to be seen in the emergency room, more likely to be hospitalized, and more likely to die over the following year. Even controlling for the impact of comorbid conditions, cognitive impairment in these older adults was significantly associated with mortality after 5-7 years of follow-up.

We are proposing a four-year randomized controlled clinical trial designed to test the efficacy of an Integrated Program of Collaborative Care as compared to usual care in improving the outcomes of care for older adults with Alzheimer Disease in a primary care setting. Although guidelines for the care of patients with Alzheimer Disease and related disorders have been published, there are no clinical trials that test the impact of close adherence to these guidelines on the outcomes of care for a group of vulnerable older adults in an urban primary care setting. We are hypothesizing that the integrated program of collaborative care, managed by a geriatric nurse practitioner who is empowered to facilitate published guidelines for care, will result in: a reduction in psychopathology and disruptive behavior among patients; a reduction in stress and depression among caregivers; a reduction in the use of skilled nursing home services, and an improvement in satisfaction with care.. The study design will also allow us to describe the prevalence of dementing disorders and associated comorbidity in primary care and to measure utilization, costs, use of community services, and the costs associated with the intervention.
Fiscal Year: 2001
Department: INDIANA UNIV-PURDUE UNIV AT INDIANAPOLIS
Project Start: 08/01/2001 - **Project End:** 07/31/2005

Grant Number: R03 HS13320
PI Name: CASTLE, NICHOLAS
Project Title: PERSISTENT POOR QUALITY IN NURSING HOMES
Abstract: A recent General Accounting Office GAO reported identified 25% of nursing homes as having serious quality problems that can either harm residents or place them at risk of death (GAO, 1999a). In addition, many of these nursing homes were identified as having chronic problems. In separate inspections, approximately 12 months apart. 40% of these homes persisted with serious quality problems, most being in the same or similar area of care. Clearly, this is a troubling state of affairs and can only add to the negative image of the nursing home industry. We are in need of research to identify which facilities have persistent poor quality, why this is the case and how improvements can be made. This proposal examines the first of these research goals. Specifically, we propose to determine which facilities have persistent poor quality.

We believe examining persistent poor quality is important. Many research have examined the quality of long term care others examined specific area of care. The majority of these studies use cross-sectional data, with the accompanying limitation that the effects identified probably include facilities with sporadic poor or high quality. Consistently poor or high quality is seldom examined, yet this represents a more refined approach to investigating the quality construct.
Fiscal Year: 2002
Department: RAND CORPORATION
Project Start: 09/30/2002 - **Project End:** 09/29/2004

Grant Number: R18 HS10926
PI Name: CONGDON, JOANN
Project Title: QUALITY FACTORS IN NURSING HOME CHOICE
Abstract: The process of selecting a quality nursing home requires that consumers have access to useful, meaningful, and appropriate information about nursing home quality. The purpose of the proposed investigation is to develop and evaluate information strategies to assist consumer use of quality factors in making nursing home choices. Specific aims include: 1) determine what information consumers use, need, and value in selecting a nursing home; 2) determine what information health care providers use, need, and value in discussing nursing home choices with consumers; 3) determine what information currently in the public domain can be used to assess nursing home quality from consumer and provider viewpoints; 4) crate a prototype report card incorporating information from Aims 1, 2, and 3 that can be used to assist consumers when choosing a nursing home; 5) examine consumer and provider responses to the prototype report card, specifically: the quality indicators, usefulness, completeness, cultural appropriateness, and format, and 6) examine whether consumer and provider responses to the prototype report card differ by urgency (timing) of the nursing home selection process. In Aims 1 and 2, a descriptive qualitative design will employ ethnographic interviews and analytic techniques with a sample of 68 newly admitted older nursing home residents, family members, and healthcare providers in eight rural and urban nursing homes. A descriptive comparative design in Aim 3 will determine the reliability and validity of available quality information. After combining data analysis result of Aims 1,2, and 3, one or more prototype reports cards will be developed (Aim 4) and evaluated with 50 consumers and providers in eight rural and urban, vulnerable older persons and families. The significance of this study is the integration of qualitative and quantitative approaches to determining the most useful and relevant indicators of nursing home quality for report card development. Use of systematic consumer quality information will motivate and inform consumers to use quality indicators as a decision tool. Identifying information enabling consumers to make value-based nursing home choices will also be useful for other healthcare settings in the continuum of long term care.
Fiscal Year: 2000
Department: UNIVERSITY OF COLORADO HLTH SCIENCES CTR
Project Start: 09/30/2000 - **Project End:** 08/31/2004

Grant Number: K02 HS00006
PI Name: COVINSKY, KENNETH
Project Title: COMPREHENSIVE OUTCOMES OF FRAIL ELDERS IN THE COMMUNITY
Abstract: The candidate is a general internist and health services researcher committed to outcomes research in frail older patients with chronic illness. His short-term career objectives are (1) to expand the scope and depth of his independently funded research program on outcomes in frail elders and (2) to extend his skills in quantitative methods and learn new qualitative methods. Long term objectives are to be a national leader in health services research in older people, to develop a geriatric health services research laboratory, and to translate his initial research findings to future studies to measure and improve the quality of care of frail elders. In addition to focused research, career development plans include interaction with colleagues on his advisory team, a formal and informal curriculum, and development of mentoring skills. UCSF will provide an outstanding environment for his career development. Resources include a research

resource lab and access to outstanding fellows within his home Division of Geriatrics, as well as the Institute on Health and Aging, and the Division of General Medicine.

The goal of the applicant's research proposal is to identify the determinants of comprehensive health outcomes (mortality, functional change, hospitalization, and quality of life) in frail nursing home eligible patients who continue to live in the community. Subjects will be patients at 12 national sites of the Program of All-Inclusive Care For the Elderly (PACE), a rapidly expanding program that cares for patients in the community that have been certified as eligible for nursing homes. The first three specific aims are to determine the predictors of mortality (aim 1), functional deterioration (aim 2), and hospitalization (aim 3) and lo develop risk adjustment models for each of these outcomes. The fourth aim is to measure health status transitions and resource use in the last year of life. The fifth aim is to understand the determinants of quality of life, from the perspective of frail elders. The first four aims rely on a novel existing data source (DataPACE) that includes comprehensive baseline and quarterly follow-up data about comorbid conditions, functional status, resource use, and vital status in 5982 ethnically diverse patients. The fifth aim will rely on semi-structured interviews of 60 patients at one of the PACE sites. The products of this research are a critical first step in developing methods to measure variations in outcomes and the quality of care, developing interventions to improve care of frail elders, and assessing the effectiveness of the rapidly growing PACE program.
Fiscal Year: 2000
Department: UNIVERSITY OF CALIFORNIA SAN FRANCISCO
Project Start: 09/30/2000 - **Project End:** 09/29/2005

Grant Number: R03 HS10663
PI Name: DUGAN, ELIZABETH
Project Title: BIOFEEDBACK AND URINARY INCONTINENCE IN OLDER WOMEN
Abstract: The broad, long-term aims of our research team are to determine
the effectiveness of behavioral and pharmacological interventions in the treatment of urinary continence in older women. Poor bladder control is a serious health problem that can have severe consequences on the independence and quality of life of older women. The aims of this 1-year pilot study are to collect critical pilot data and experience prior to a larger, more complex clinical trial. This pilot study aims to: Assess our ability to recruit participants to participate in a randomized clinical trial of the efficacy of biofeedback in treating urinary incontinence; provide experience with intervention materials, data collection procedures, and participant management related to the proposed clinical trial; provide confidence in the hypothesis that our regimens of biofeedback are associated with clinically meaningful treatment effects. Thirty women aged 50-65 will be randomized to one of three conditions: 6 treatments of biofeedback-assisted behavioral therapy, 3 treatments of biofeedback-assisted behavioral therapy, and control (pelvic floor exercise, self-monitoring, and urge strategy instruction). Subjective self-report data and objective continence severity measures will be used. In addition, data will be collected on: generic and incontinence-specific quality of life, adherence to pelvic floor exercises, adherence to biofeedback, patient satisfaction and treatment preferences. Descriptive statistics, such as counts, frequencies, and means will be calculated for all variables. Analyses will be conducted primarily using SAS software.
Fiscal Year: 2000
Department: WAKE FOREST UNIVERSITY HEALTH SCIENCES
Project Start: 07/01/2000 - **Project End:** 12/31/2001

Grant Number: R01 HS10322
PI Name: FENNELL, MARY
Project Title: FACILITY EFFECTS ON RACIAL DIFFERENCES IN NH QUALITY
Abstract: This project would explore the ways in which nursing home structure and the local community contexts interact to affect the quality of care experienced by white and minority nursing home residents. The specific aims of the projects are to: quantify the extent to which access to nursing home care is

segregated by race and ethnicity; develop a measure of racial/ethnic disparities in care quality that compares the odds of receiving poor quality care for whites and nonwhites; examine variation in and relationships between the two separate concepts of nursing home quality of care and racial/ethnic disparities; test for the effects of demographic "mismatch" between community and nursing home staff on racial/ethnic disparity; and develop and test a multilevel model explaining variation in nursing home quality of care as well as racial/ethnic disparities as a function of patient level, facility level and community level factors.
Fiscal Year: 1999
Department: BROWN UNIVERSITY
Project Start: 09/30/1999 - **Project End:** 09/29/2002

Grant Number: R01 HS10542
PI Name: FELDMAN, PENNY
Project Title: Evidence-Based 'Reminders' in Home Health Care
Abstract: In recognition of the great need for tested, efficacious, affordable strategies to translate evidence-based practice guidelines into home health practice, AHRQ supported the parent project to this application. Substantial progress has been made in meeting the original study objectives of the parent project in which we are testing the relative effectiveness and cost-effectiveness of two alternative information-based strategies intended to improve provider performance and promote adherence to evidence-based practice guidelines among home health care nurses. A basic and an augmented intervention are being tested. The basic intervention provides nurses with a "just-in-time" e-mail reminder highlighting six condition-specific practices they should follow to achieve optimal outcomes for patients with one of two tracer conditions: heart failure or cancer pain. In the augmented intervention, additional information on evidence-based practice is provided to nurses along with consulting services from an "expert peer." The study employs a randomized design that assigns nurses to one of the two treatment groups or a usual care control group. We are now in the final six months of what was planned as a two and one-half year project. The enrollment of heart failure patients and most analyses for this tracer condition will be completed before the end of the current grant period. Enrollment of cancer pain patients has been slower than anticipated due to a variety of exogenous factors and a relatively high proportion of individuals being unavailable for an interview due to death, institutionalization or extended hospital stays. Additional time and resources are needed to accrue sufficient numbers of cancer pain patients to detect small-to-moderate clinically meaningful intervention effects on patient outcomes and other measures. A new aim is also being proposed in this application. Specifically, we want to extend data collection on a subset of the cancer pain patients - those with "malignant" (as opposed to post-operative) pain. While the interventions are appropriate for all cancer pain patients, further data collection would allow separate examination of the effect of the interventions on a very vulnerable group, patients with malignant pain, who may derive particular benefit from the implementation of evidence-based pain management practices in home health care.
Fiscal Year: 1999
Department: VISITING NURSE SERVICE OF NEW YORK
Project Start: 09/30/1999 - **Project End:** 03/31/2004

Grant Number: R01 HS11962
PI Name: FELDMAN, PENNY
Project Title: Working Conditions & Adverse Events in Home Health Care
Abstract: This project will examine the relationships that exist between and among key features of the organizational work place, the work force and adverse patient events due to preventable errors in the home health care setting. Taking advantage of the natural variation in working conditions across 83 teams in a very large home health agency, the project will estimate the effects of variations in team culture and staffing, as well as individual nurse characteristics and productivity, on adverse patient events. It also will examine the relationship between patient care errors and selected adverse events. Measures of work environment and work force characteristics will include both objective and subjective measures and will be obtained from a combination of routine administrative and clinical data, plus project-specific primary data,

including a survey of frontline nurses and managers. Measures of adverse patient events will be drawn from a set of 13 measures developed by the Health Care Financing Administration for home health care, supplemented by a small number of additional measures selected with input from an expert panel. The project will employ qualitative methods (interviews, expert panel, focus groups) to elaborate the conceptual model and hypotheses, as well as to review and interpret the findings of the quantitative analyses. It will employ econometric techniques, including the use of instrumental variables, to model episode and patient level outcome data (adverse events) at the team and nurse level. It also will involve record review and statistical analysis to assess the strength of the relationship between patient care errors and 3 types of adverse event. The project will be one of the few theory-driven empirical, quantitative studies of home health care quality. It should lead to sounder intervention research and contribute to the broader literature on working conditions, service quality, and patient safety.
Fiscal Year: 2001
Department: VISITING NURSE SERVICE OF NEW YORK
Project Start: 09/30/2001 - **Project End:** 09/29/2004

Grant Number: U18 HS13694
PI Name: FELDMAN, PENNY
Project Title: Partnership for Achieving Quality Homecare
Abstract: This project will launch a national partnership among home health care providers to improve care for a priority population--elderly home care recipients. The goal is to create a model and establish an infrastructure through which collaborating organizations can 1) identify and prioritize aims for improvement, and 2) gain access to methods, tools, and materials that will enable them to conduct more sophisticated, evidence-based quality improvement activities than they could individually. The partnership will initially comprise six home health agencies from across the United States and will expand to include additional partners and/or additional substantive targets over a four-year period. A learning collaborative model, adapted from the successful breakthrough series approach developed by the Institute for Healthcare Improvement (IHI), will be created to serve as a central mechanism of the partnership. Through the learning collaborative, partnership members will develop the skills to apply state-of-the-art methods to implement evidence-based practices to improve overall quality of care and patient outcomes. Topics for collaborative improvement activities will be chosen, depending on member need and the availability of an appropriate evidence base, from priority conditions--such as diabetes management, wound care, or pain management--among both home care and general patient populations. The development of a "tool kit" of materials and techniques will provide existing and prospective partnership members, as well as other home health care organizations interested in quality improvement, with easily accessible resources for translating research findings into daily practice. The project will conclude with the dissemination of results and lessons learned at a national conference.
Fiscal Year: 2002
Department: VISITING NURSE SERVICE OF NEW YORK
Project Start: 09/30/2002 - **Project End:** 09/29/2006

Grant Number: R03 HS10787
PI Name: GOLLUB, ELIZABETH
Project Title: COST EFFECTIVE NUTRITIONAL WELL-BEING IN OLDER ADULTS
Abstract: This study would add onto studies that have already been conducted by the National Policy and Resource Center on Nutrition and Aging at Florida International University. This study would compare patients enrolled in the Older Americans Act Elderly Nutrition Program (ENP) receiving a noon meal with an intervention group also receiving breakfast. A cross-sectional field design would be used. Each group would consist of 200 participants recruited from 8 sites that were evaluated for a Morning Meals on Wheels (MMOW) program. A questionnaire will be administered once to each participant to collect information on sociodemographic factors, nutritional status, quality of life, depression, ADLs and IADLs, hunger and food insecurity, food enjoyment, loneliness, program satisfaction, health care utilization, and program costs. The two groups of patients will be compared using various bivariate and multiple regression methods.

Fiscal Year: 2000
Department: FLORIDA INTERNATIONAL UNIVERSITY
Project Start: 09/01/2000 - **Project End:** 01/30/2002

Grant Number: R03 HS11457
PI Name: GOZALO, PEDRO
Project Title: Access to Medicare Hospice for Nursing Home Residents
Abstract: Recent research suggests that Medicare hospice care provides important benefits to dying nursing home (NH) residents. Research shows hospice enrollment is associated with a greater probability of residents having their pain assessed and managed and with a lesser probability of being hospitalized at the end-of-life. However, enrollment in Medicare hospice is not available to all NH residents. NH residents can only elect hospice if a NE has a contract with a hospice provider, and in practice, not all NHs have such contracts. Furthermore, not all NH residents with access to hospice choose the benefit and the incentives of the NE and hospice providers will likely influence this decision. An understanding of how this double-layer selection process functions is essential to understanding access to hospice in NHs and to developing statistical and economic models that most fully consider selection biases.
In this proposed project we examine the process by which the Medicare hospice benefit becomes available to terminally ill NH residents, and when available, the process by which the residents select the benefit. We propose a model of endogenous decision making that takes advantage of a rich longitudinal data set linking Medicare claims, nursing home and hospice providers data and Minimum Data Set (MDS) clinical information in the state of Ohio. The study Aims are: (1) Measure the effects of nursing homes, hospice providers and market characteristics on the availability of hospice in nursing homes, and (2) Measure the effects of patient, nursing home and hospice provider characteristics on the election of Medicare hospice benefit by eligible nursing home patients. The model and data emanating from this study will be used in the development of an RO I proposal to be submitted at the end of the project period. This project, and subsequent work, will be important to policymakers for monitoring hospice care provision and for deciding on future changes in the administration of the Medicare hospice benefit.
Fiscal Year: 2001
Department: BROWN UNIVERSITY
Project Start: 07/01/2001 - **Project End:** 06/30/2003

Grant Number: R03 HS11702
PI Name: GRABOWSKI, DAVID
Project Title: Medicaid Payment and Risk Adjusted Nursing Home Quality
Abstract: Quality of care problems have persisted for decades within nursing homes caring for Medicaid beneficiaries. Previous research has attributed these problems in part to certificate-of-need (CON) laws and construction moratoria, which are designed to control government expenditures by limiting the number of nursing home beds in an area. Such policies create barriers to entry and can result in excess demand for Medicaid funded nursing home care and therefore limit competition on the basis of quality. In markets with excess demand for care, an increase in the level of Medicaid reimbursement has not been found to improve the quality of care. However, declines in recent bed occupancy trends suggest the overall effect of CON and moratoria regulations may be lessening within markets for nursing home care. Indeed, more recent studies have found a modest positive relationship between Medicaid reimbursement rates and quality.

A common limitation across previous studies of nursing home quality is the lack of resident-level data needed for adequate risk adjustment of quality measures. Any relationship between reimbursement rates and quality (positive or negative) may be masked or distorted in the absence of risk-adjusted quality measures. We propose to examine the effect of Medicaid reimbursement rates on nursing home quality in the context of CON/moratoria policies using risk-adjusted quality measures (outcomes and staffing) from every nursing home in the United States. By merging data from the Minimum Data Set (MDS), the Online Survey, Certification and Reporting System (OSCAR) and the Area Resource File (ARF), the proposed study will greatly increase our understanding of the role of Medicaid reimbursement and CON/moratoria

policies in encouraging the provision of high quality care in nursing homes.
Fiscal Year: 2001
Department: UNIVERSITY OF ALABAMA AT BIRMINGHAM
Project Start: 09/15/2001 - **Project End:** 09/14/2003

Grant Number: R01 HS10481
PI Name: GURWITZ, JERRY
Project Title: REDUCING ADVERSE DRUG EVENTS IN THE NURSING HOME
Abstract: Medications are pervasive in long-term care, representing an efficacious and cost-effective therapeutic modality. However, nursing-home [NH] residents are at increased risk for experiencing adverse drug events [ADEs]. ADE risk is increased by the physiologic decline and pharmacologic changes that occur with aging, and by the clinical and social circumstances of institutional long-term care. In a previous NIA study (AG 14472), the investigator determined that NH ADEs are common and often preventable, and that the more serious the ADE are more likely to be preventable. Here, he would test whether a computer-based clinical decision support system can lower the rate of ADEs and potential ADEs in NHs. This is a randomized trial based in the resident care units of two large NHs. Within each facility, half of the resident care units will be randomized to an intervention arm receiving the computer-based clinical decision support system. This system will display warnings, messages, and prompts based on resident and drug use characteristics, with over-rides by the prescriber required for some warnings. ADE and potential ADE rates will be tracked by the study's on-site clinical pharmacists prior to and during the intervention period. Rates will be compared between experimental and control units, and to pre-intervention rates in the same units. The investigator will track all project costs directly related to the development and installation of the decision support system. He will also develop and test the sensitivity and specificity of a computerized ADE monitor and assess the validity of an NH resident risk model developed in his prior study of NH ADEs.
Fiscal Year: 2000
Department: UNIV OF MASSACHUSETTS MED SCH WORCESTER
Project Start: 07/01/2000 - **Project End:** 06/30/2004

Grant Number: R03 HS11482
PI Name: HARADA, NANCY
Project Title: PATTERNS OF REHABILITATION USE FOLLOWING STROKE
Abstract: Stroke is the leading cause of disability and the third leading cause of death in the United States. After suffering a stroke, the pattern of acute and postacute rehabilitation is often determined by the physician with consideration of the patient's clinical status and the health care delivery system. As a result, the types of acute and postacute services received by stroke patients may vary substantially. This study focuses on the movement of patients from the acute hospital to postacute (skilled nursing facility (SNF) and/or freestanding rehabilitation hospital) settings. The specific aims are to: (1) compare and contrast the demographic, clinical, and organizational characteristics of stroke patients who receive six different patterns of rehabilitation use: acute hospital rehabilitation only; acute hospital and SNF rehabilitation; acute hospital and freestanding rehabilitation hospital care; SNF rehabilitation only; freestanding rehabilitation hospital care only; and no rehabilitation; (2) to compare and contrast facility length of stay by rehabilitation use pattern and identify characteristics associated with length of stay; (3) to compare and contrast total episode days of care by rehabilitation use pattern and identify characteristics associated with total episode days of care; and (4) to compare and contrast discharge destination by rehabilitation use pattern and identify characteristics associated with discharge destination. To accomplish these aims, we will conduct a cross-sectional, secondary analysis of Fiscal Year 1995 administrative data obtained from the Health Care Financing Administration. Several datasets will be merged to develop an analytical file that contains demographic, clinical, facility, and resource use variables. The specific data sets to be merged are: the Medicare Provider Analysis and Review File, Provider Specific File, Hospital Cost Report Information System Minimum Data Set, and SNF Minimum Data Set. Data will be analyzed using multivariate techniques. The findings of this study will contribute towards our current knowledge of how patterns of

rehabilitation utilization throughout an episode of care influence clinical outcomes of care. The findings have implications for the development of an integrated payment system for postacute services.
Fiscal Year: 2001
Department: RAND CORPORATION
Project Start: 08/01/2001 - **Project End:** 07/31/2003

Grant Number: R01 HS10315
PI Name: HAWES, M
Project Title: QUALITY MEASUREMENT IN RESIDENTIAL CARE
Abstract: The overall purpose of this application is to develop quality measures for residential care facilities. These quality measures can then be used in external quality-assurance systems, consumer report cards, and in a feedback system for providers. An offshoot of this effort will be to develop quality-improvement protocols for residential care facilities (RCF). Finally, the project will lead to an acuity-based reimbursement model for such facilities. One million aged and disabled individuals reside in residential care facilities, which are also called group homes, board-and-care homes, personal care homes, and assisted living. In contrast to nursing homes, there is very little regulatory control over these homes, and virtually no information about quality of care. The applicant proposes to define and operationalize valid and reliable quality measures that can be used to evaluate the performance of RCFs; to risk-adjust the quality measures with relevant individual or organizational characteristics; to develop facility-level report cards that can be used in various ways; to develop and test quality-improvement protocols; to develop a resident classification model for use in adjusting payment rates; and to disseminate results to state policy-makers and relevant others. The applicants will accomplish these goals by using primarily the Maine Minimum Data Sets for residential care facilities as well as licensure data from Maine and cost-report data. In addition, they will have data from several other prior studies that they participated in from North Carolina and they will also collect primary data to assist in their development of quality indicators, with site visits to RCFs in Maine.
Fiscal Year: 1999
Department: MENORAH PARK CTR FOR THE AGING MYERS RES
Project Start: 09/30/1999 - **Project End:** 09/29/2004

Grant Number: R13 HS12057
PI Name: HELMS, DAVID
Project Title: LONG-TERM CARE RESEARCH AND SERVICE DELIVERY
Abstract: The Academy for Health Services Research and Health Policy (Academy) is pleased to submit this application to the Agency for Healthcare Research and Quality (AHRQ) to conduct a research development conference that will address the role of research in strengthening service delivery in long-term care (LTC). Conference participants will begin to identify ways in which researchers, LTC providers, and policymakers can work together to identify research needs and incorporate research findings into LTC service delivery and policy decisions. The conference will help to foster strong alliances among these stakeholders and encourage action to address the many complexities of LTC. Finally, the conference will serve as the backdrop for a number of written products which will be widely disseminated to researchers, providers and policymakers. We anticipate that the conference will be sponsored by a coalition including The Retirement Research Foundation, AARP and The Robert Wood Johnson Foundation, in addition to AHRQ, and will be conducted by the Academy. To date, the Academy has received a grant in amount of $48,878 from The Retirement Research Foundation, and the proposal has received positive staff support from the Robert Wood Johnson Foundation (RWJF), where it is awaiting a final funding decision. The attached letter also demonstrates AARP's support for the project. We have requested funding of approximately $10,000 from AARP and $90,000 from the RWJF. The Academy will achieve the goals of the conference through four major tasks: 1) plan and conduct a Planning Committee meeting; 2) plan and

conduct an Invitational Conference; 3) reconvene a group (likely a subset of the planning committee) to evaluate the key products of the conference as a whole; and 4) write a final report, circulate it for comment to the planning committee, and disseminate the report, submitting other written materials generated from the conference for publication consideration. The commissioned papers and conference discussion will be organized around two themes:
- Service Delivery Research, including issues of improving care from an operational perspective, the consumer/family role, using information services, integrating acute/chronic care, and staffing.
- Policy Research, including issues of financing, state and federal regulation, and licensor.

The two commissioned papers will be written by researchers very familiar with pragmatic issues in LTC service delivery and policymaking: one by someone very familiar with service delivery issues, such as Penny Feldman, and one by someone very familiar with the financing and regulatory issues, such as Joshua Wiener. We will instruct the paper writers that they should meet with/interview key stakeholders, including those in the industry, so that their papers include some real world examples/perspectives, rather than just a review of the research literature. The papers will be written for a non-research audience, particularly providers and policymakers. The two commissioned papers will be used as vehicles for stimulating conference discussion and ideas for partnerships among these constituencies. As noted in the draft agenda in Appendix A, panelists who are service providers or policymakers will be asked to respond to each of the paper presentations. The panelists will help to identify how LTC researchers might "push the envelope" and develop innovative ways to address important issues.
Fiscal Year: 2001
Department: ACADEMYHEALTH
Project Start: 09/30/2001 - **Project End:** 09/29/2002

Grant Number: U18 HS13696
PI Name: HORN, SUSAN
Project Title: Real-time Optimal Care Plans for Nursing Home QI
Abstract: The objectives of the proposed study are to design, support, and facilitate change that, according to evidence from the National Pressure Ulcer Long-Term Care Study (NPULS) and other published sources, is likely to lead to documented improvements in health care quality and ensure that these improvements become part of the ongoing practice of health care providers and clinicians. This project will broaden the partnerships originally established in 1996 for the NPULS to implement best practices in long term care. Key aims of our study are to: build partnerships to promote cooperation in implementing quality improvement strategies in long-term care facilities; incorporate evidence-based best practices into everyday workflow using technology to automate data collection; manage and track information, and support clinical decision-making and care planning; and enhance education strategies to include principles of CPI and organizational change. We also plan to facilitate clinical process redesign. We must redesign the process rather than just improve existing processes. We intend to design, test, and evaluate automated processes to transmit evidence-based information and provide decision support for providers in nursing home practice. The information technology tools will enable automation of protocol driven care: patient assessment, daily documentation flow sheets, alerts or prompts for specific interventions based on patient needs, tracking specific interventions delivered based on best practice, and summarizing documented clinical information in a variety of formats previously requiring a chart pull and abstraction. The specific objectives of this project are to: 1) Develop partnerships committed to integrating Clinical Practice Improvement study results into daily practice; 2) confirm priority improvement areas and measurable objectives; 3) Gather input from Advisory Board and Working Group to augment results of NPULS; 4) Develop implementation strategy, materials and tools for implementation, and detailed implementation plans for each participating site; 5) Facilitate implementation and sustain process: and 6) Evaluate results and develop plans for ongoing initiative to expand participating sites.
Fiscal Year: 2002
Department: INTERNATIONAL SEVERITY INFO SYSTEMS, INC.
Project Start: 09/30/2002 - **Project End:** 09/29/2006

Grant Number: U18 HS11093
PI Name: JONES, KATHERINE
Project Title: IMPROVING PAIN MANAGEMENT IN NURSING HOMES
Abstract: Inadequate pain management has been well documented across health care settings. It is a particular problem in nursing homes, which have a high prevalence of pain but face significant barriers to its effective diagnosis and treatment. Barriers include staff knowledge deficits, sociocultural beliefs about pain and pain medication held by residents, family members, and staff, and system issues such as staffing levels, turnover, and drug formulary policies. Residents who are cognitively impaired or are from racial/ethnic minority groups are at higher risk for inadequate analgesia. This study proposes to develop and implement a culturally-competent intervention to improve the quality of pain management in nursing homes. Development of the educational materials is based on principles of competency-based education and adult learning. Implementation strategies are based on innovation diffusion theory. Specific aims are to 1) develop and implement a multi-modal, culturally-competent, evidence-based educational and behavioral intervention to improve pain assessment and pain management in nursing homes; 2) improve pain assessment procedures and pain management strategies being used in nursing homes; 3) improve resident, family, and staff knowledge and attitudes towards pain assessment and pain management; 4) evaluate the influence of organizational variables on achieving desired clinical and educational outcomes; and 5) assess the cost-effectiveness of the multi-modal intervention for disseminating pain assessment and pain management knowledge to nursing homes. Specific intervention components include videotapes and manuals for staff training; a pain resource binder; physician and pharmacist seminars; chart review and feedback to clinicians; creation of an internal pain team; site visits and interactive television conferencing. Specific methods for measuring the impact of the intervention include focus groups, surveys, resident interviews and observations, chart review, organizational observations, and secondary data analysis using the Minimum Data Set. The uniqueness of this project is its attention to cultural variability in pain assessment and treatment through the inclusion of Spanish speaking staff and residents, development of Spanish versions of the intervention, use of an interdisciplinary internal pain team to sustain change, and incorporation of the existing AHEC infrastructure for communication and coordination across settings, facilitating future extension of the educational program.
Fiscal Year: 2000
Department: UNIVERSITY OF COLORADO HLTH SCIENCES CTR
Project Start: 09/27/2000 - **Project End:** 05/31/2004

Grant Number: P20 HS11523
PI Name: KOVNER, CHRISTINE
Project Title: Patient Safety in Home Care
Abstract: The New York University Division of Nursing (NYU-DON) and the Center for Home Care Policy and Research (CHCPR) at the Visiting Nurse Service of New York VNSNY) propose to establish a Developmental Center for Evaluation and Research in Patient safety (DCERPS). The DCERPS will focus on health care provided in the home setting, particularly on care provided by nurses, and its relationship to patient safety in home care. Home care is a significant sector of the health care system that has received little attention, even though patient adverse events resulting from medical errors have been a focus of heightened professional, public, and Congressional (GAO, 2000) concern, especially since publication of the Institute of Medicine's report To Err is Human (Kohn, 1999). In recent years, physician-related errors and patient injuries occurring in hospitals and nursing homes have been the most widely studied, while less is known about errors in non-institutional settings (Rothschild & Leape, 2000; Gurwitz, 1994).

The goal of the NYU-VNSNY DCERPS is to establish an ongoing center that can provide the intellectual resources and disciplinary skills, the measurement tools and the organizational techniques for understanding medical errors in home health care and designing and evaluating mechanisms for learning from such errors and reducing them. Over the next three years (Phases 1 and 2 of the project) our goals and to 1) develop a multi-disciplinary team to conduct research on patient safety, 2) strengthen the ties between NYU-DON and VNSNY, 3) develop educational programs on the importance of patient safety and evidence-based approaches to improving it, and 4) conduct research pilot studies. The DCERPS will

mobilize resources from both institutions, as well as selected outside consultants, and will include a multidisciplinary team of registered nurses (RNs), physicians, social scientists, statisticians, and epidemiologists, and management experts. The prime focus of our work will be care provided to older adults and minority groups in inner-city areas. Unlike many home health agencies, VNSNY has a large nonwhite population. Approximately two-thirds of the patients served by VNSNY are 65 or older, while about 3 out of 10 are black and 2 out of 10 are Hispanic.
Fiscal Year: 2001
Department: NEW YORK UNIVERSITY
Project Start: 09/30/2001 - **Project End:** 09/29/2004

Grant Number: R18 HS11835
PI Name: LAPANE, KATE
Project Title: Pharmacist Technology for Nursing Home Resident Safety?
Abstract: In nursing homes, the average resident uses six different medications and 20% use at least 10 different medications. Given the medical complexity of nursing home residents, the use of multiple medications may be clinically appropriate. Yet, changes in pharmacokinetics and pharmacodynamics make older persons more vulnerable to adverse medication effects, placing them at increased risk for adverse drug events (ADES). Gurwitz et al deemed 1.39 ADES per 100 resident months as fatal, life-threatening, or serious. Of preventable ADES, 70% occurred at the monitoring stage of the medication use process. Indeed, "...patients may be experiencing unnecessary adverse medication reactions as a result of inadequate monitoring of medications." (OIG, 1997) Few patient safety systems use information technology in the monitoring stage. Our proposal is unique in that we aim to test information technology designed specifically to alert prescribers and nursing facility staff to inf6rmation that can reduce the threat to patient safety associated with ADES using a unique clinical tool for health professionals (Geriatric Risk Assessment MDS Med Guide (GRAM)). The GRAM software is intended to assist in the decision-making process of evaluating complex medication regimen of older patients; facilitate incorporation of patient assessment data in the monitoring of medication therapy; and foster inclusion of recommendations in the care plan to prevent avoidable medication-related problems. We propose a large-scale randomized trial. We will recruit 26 nursing homes; half will receive the intervention. Evaluation of the project relies on existing data sources to trigger in depth chart reviews. We will determine the extent to which the use of the GRAM clinical tool increases the incorporation of monitoring recommendations to detect ADEs into the resident care plan; reduces the incidence of delirium, falls with and without fracture, (the two most common ADES in LTC) and hospitalizations due to ADES; reduces the triggering of resident assessment protocol (RAPS) triggers for delirium and falls. We will also quantify the impact of the GRAM software on the efficiency, productivity, workload, and job satisfaction of the consultant pharmacists and nursing facility staff.
Fiscal Year: 2001
Department: BROWN UNIVERSITY
Project Start: 09/30/2001 - **Project End:** 09/29/2004

Grant Number: R13 HS10967
PI Name: LAWHORNE, LARRY
Project Title: UNITING PRACTICE AND RESEARCH IN LONG TERM CARE
Abstract: The AMDA Foundation's research development conference, "Uniting Practice and Research in Long Term Care", tentatively scheduled for November 2-3, 2001 is a central component of the implementation of a newly formed practice-based research network of medical directors in long term care facilities. The conference will set a national research agenda for the long term care research network. It will provide training to network members in research methodologies, disseminate information on seminal long term care research studies, and help identify and nurture new principal investigators. By bringing together academic researchers and community based medical directors, it will provide a unique forum for collaboration and development of one or more well-defined network research projects.
Fiscal Year: 2001
Department: AMERICAN MEDICAL DIRECTORS ASSOCIATION

Project Start: 09/30/2001 - **Project End:** 09/29/2002

Grant Number: R13 HS13806
PI Name: LAWHORNE, LARRY
Project Title: Conference--Patient Safety Issues in Long Term Care
Abstract: The AMOA Foundation's research development conference, "Patient Safety Issues in Long Term Care" will further the development of the research agenda for the AMOA Foundation Long Term Care Research Network, a national practice-based research network of long term care professionals launched in 2001. The conference will identify new research priorities and studies surrounding the issue of patient safety in long term care with an emphasis on using performance measures (e.g., quality indicators, survey deficiencies hospitalizations) and data sets (MOS, OSCAR, FIB) to compare research results against national norms. The conference will also examine how the Research Network can collaborate with users of large data sets to explain variations in practice patterns and outcomes that are observed in these large data sets, such as geographic variations in the use of feeding tubes. Findings of research studies initiated in 2001 and their implications for improving quality and patient safety in long term care will also be discussed.

We will also discuss benefits and limitations of existing research methodologies and data collection instruments currently being used in the Network and identify new ones that are feasible for the Network to implement. We will provide training about the role of the site investigator in educating IRBs and their facilities about research issues in long term care, including human subject protection and privacy.

Conference faculty will include leading national experts in long term care research, as well as experts on patient safety and nursing home quality initiatives from AHRQ and CMS.
Fiscal Year: 2002
Department: AMERICAN MEDICAL DIRECTORS ASSOCIATION
Project Start: 09/30/2002 - **Project End:** 09/29/2003

Grant Number: U18 HS11113
PI Name: LOEB, MARK
Project Title: Optimizing Antibiotic Use in Long-Term Care
Abstract: The primary aim of this study is to determine if an evidence-based clinical algorithm for managing urinary tract infections (UTIS) in older adults in residential long-term care facilities (LTCFs) can reduce the overall use of antibiotics in LTCFs. Three secondary objectives are: 1) to demonstrate the feasibility of implementing diagnostic and therapeutic evidence-based clinical algorithms in LTCFs; 2) to assess the safety of reducing the number of diagnostic tests and antibiotic use for UTIs in the target population; 3) to evaluate the process of adopting the algorithms in LTCFs. This study will use a combined quantitative and qualitative approach to evaluate the process and outcomes of implementing a clinical algorithm to optimize the use of antibiotics in residential LTCFs. For the quantitative component of the study, a randomized matched pair design has been used where, within each of the 12 pairs of LTCFs, one was randomized to the intervention (clinical algorithm). The other half is providing "usual" management of presumptive urinary tract infections. Quantitative outcomes include 1) the proportion of antibiotic courses prescribed for urinary indications, 2) the total number of courses of antibiotics used, 3) rates of urine cultures ordered, 4) hospitalization rates for urinary tract infections, and 5) mortality rates. The qualitative Component of the study will be a prospective Case study evaluation of the clinical algorithms. This component of the study will exam the ease of implementation and health care provider satisfaction with the algorithms.
Fiscal Year: 2000
Department: MC MASTER UNIVERSITY
Project Start: 09/30/2000 - **Project End:** 08/31/2004

Grant Number: R01 HS10230
PI Name: MACIEJEWSKI, MATTHEW
Project Title: SELECTION BIAS BY MEDICARE BENEFICIARIES WITH DIABETES
Abstract: The purpose of this study is to examine the effect of Medicare HMO enrollment on the mortality and cost of care for Medicare beneficiaries with diabetes between 1994 and 1998. There are two major public policy concerns regarding individuals with chronic conditions that enroll in Medicare HMOs: Does Medicare contain costs by encouraging people with chronic diseases, such as people with diabetes, to join TEFRA-risk HMOs? and Are the quality of care and health outcomes provided to these enrollees comparable to those in the fee-for-service sector? This study will provide insight into both of these questions using Medicare administrative data from 1992 to 1998.

This proposal will extend recent work by Dowd, et al., (1998) and Maciejewski, et al. (2001) looking al based selection of the general Medicare population into TEFRA-risk HMOs. It will use a unique dataset (the National Medicare Diabetes Cohort), which contains 2.5 million elderly Medicare beneficiaries with diagnosed diabetes mellitus in fee-for-service plans in 1994. The following specific research questions will be addressed:

1) Do healthier beneficiaries with diabetes systematically enroll in Medicare HMOs?

2) Do HMO enrollees with diabetes have different five-year survival rates than Medicare beneficiaries with diabetes who remain in the fee-for-service (FFS) sector?

3) Do unhealthier beneficiaries with diabetes systematically disenroll from Medicare HMOs?

4) Do HMO disenrollees with diabetes have different FFS costs than Medicare beneficiaries who remain in the FFS sector?

The careful analysis of enrollment and disenrollment patterns of this chronically ill population, combined with the mortality and cost analyses, will provide insight into the advantages and disadvantages of enrollment in Medicare HMOs. Analyses will be conducted on a cohort of beneficiaries with diabetes in the fee-for-service sector in 1992-1993, so results are not generalizable to people with diabetes who enrolled in Medicare HMOs prior to 1994.

Grant Number: R03 HS13412
PI Name: MURRAY, PATRICK
Project Title: Outcomes of the Nursing Home Prospective Payment System
Abstract: The specific aims of the project are: 1. to describe the changes in provision of rehabilitation services to newly admitted nursing home patients following the implementation of the Nursing Home (NH) Prospective Payment System (PPS) 2. to detail changes in rehabilitation services by diagnostic group and propensity to receive rehabilitation. 3. To evaluate the effect of these changes on survival and community discharge rate by comparing pre and post-PPS cohorts.

Background: During the 1990's there was a rapid growth in the amount of rehabilitation therapy provided in NHs induced by discharge of patients from hospitals "sicker and quicker" and supported by changes in Medicare reimbursement policy. Patients who received rehabilitation services have been shown to have faired better in terms of discharge outcomes and survival than similar patients who did not receive such services. The new PPS for NHs reduces the financial incentives to NHs to provide rehabilitation services. This research will examine the magnitude of the change in rehabilitation services during the early post PPS period and the effect of the changes on important outcomes that have been reported in the past.

Outcomes: Community discharge rates 3 months following the initial NH admission, operationalized by linking death records and longitudinally collected Minimum Data Set (MDS). Survival as operationalized by linking the MDS to the death records.

Methods: Selection bias will be controlled using a previously developed propensity model employing 110 variables derived from the MDS. The propensity model will be developed and validated in a split pre-PPS sample and then applied to the patients in the post-PPS period to predict their propensity to receive these services, controlling for inter period selection differences. Susceptibility to long term NH residence and death will be directly controlled through 21 clinically chosen MDS variables. The primary analytic approaches will be case matching and multivariable modeling (logistic or proportional hazards). The success of the propensity modeling in controlling for selection bias will be confirmed using the case matching protocol. The study will provide valuable information concerning the results of a major public policy change in the funding of NH services.
Fiscal Year: 2002
Department: CASE WESTERN RESERVE UNIVERSITY
Project Start: 09/30/2002 - **Project End:** 09/29/2004

Grant Number: P20 HS11588
PI Name: OUSLANDER, JOSEPH
Project Title: Devel Ctr for Eval & Res in Pt Safety in LTC
Abstract: The proposed developmental center for evaluation and research in patient safety will focus on one of the most rapidly growing segments of the U.S. population, and one that is especially vulnerable to medical errors and injuries: frail older residents of long-term care (LTC) institutions (including both nursing homes and assisted living facilities). The "DCERPS - LTC" will be a collaboration of Emory University, two Historically Black Institutions (Morehouse School of Medicine and Shaw University), the VA VISN 8 Patient Safety Center, a network of LTC providers ("the Southeast Consortium for LTC Quality"), the state department of health services, provider and consumer organizations, and a panel of national experts. The DCERPS - LTC will focus on preventing two of the most painful and costly injuries that can result from medical errors in LTC: injurious f alls and pressure ulcers. During the first year planning phase a multidisciplinary team of investigators encompassing expertise in Geriatric Medicine, Gerontological Nursing, Physical Therapy, Health Services Research, Epidemiology, Economics, Human Factors, Psychology, and Sociology will develop and test culturally sensitive educational materials and quality improvement (QI) tools that focus on the prevention of injurious falls and pressure ulcers and the related clinical problems of mobility disorders and urinary incontinence. The team will also further develop a pilot study that' will be conducted during project years 2 and 3. The pilot study will address several factors that can play an important role in medical errors and patient injuries in LTC facilities, including: lack of education among LTC staff and primary care providers on risk factors for patient injuries; lack of effective tools that facilitate documentation and communication among LTC staff and primary care providers; and sub-optimal use of information systems. Two examples of pilot studies are included in the application that will utilize the educational products and QI tools developed in the planning phase, and address 3 of the 4 key topic areas in the RFA: learning from errors and communicating that information; issues related to systems and cultures; and implementing informatics strategies. The educational products, QI tools, and pilot study results will be disseminated in collaboration with an External Advisory Group representing local and national organizations. The long-term goal is to develop a center that will design and implement interdisciplinary, multi-institutional projects targeted at reducing patient injuries in LTC facilities.
Fiscal Year: 2001
Department: EMORY UNIVERSITY
Project Start: 09/30/2001 - **Project End:** 09/29/2004

Grant Number: R01 HS12031
PI Name: PARKER, VICTORIA
Project Title: Task Design, Motivation and Nursing Home Care Quality
Abstract: Unlike many other domains of health care, the provision of high quality nursing home care depends on relatively untrained workers executing the same basic tasks each day, without many of the high stakes, unexpected, confusing situations that are often associated with omissions and errors in health care.

In nursing home care, quality is compromised when workers as a group consistently neglect elements of good basic care; for example, when failure to regularly reposition immobile residents leads to the development of pressure ulcers. The likelihood of such occurrences is heightened by the problems of worker recruitment and retention in the low-skill, low-paying jobs that are central to the provision of such care. Research across many industries has found that several characteristics of how jobs are designed can be changed in ways that influence work motivation; creating conditions that make jobs more motivating, eliciting improved performance, and reducing turnover. Task design features are important at both the level of individual jobs and at the level of jobs performed by groups or teams. We hypothesize that variation in job design, at both the individual and group levels, is associated with differences in staff satisfaction and with differences in care quality indicators.

We will study 25 nursing homes, collecting data from several sources. We will administer the Job Diagnostic Survey to nursing home employees to collect data on the design of individual jobs, and on employee job satisfaction, across multiple job categories, primarily nurse aides and licensed practical nurses. Data about group task design will be collected through structured observation and interviewing of a sample of managers and 'employees in each nursing home. Commonly accepted quality indicators derived from the Minimum Data Set (MDS) will be used to assess care quality. Analyses will relate job design characteristics to employee job satisfaction and to care quality.

This study will provide important information regarding the variation among nursing homes in the task design of nursing care jobs, and about how such variation is related to differences in worker outcomes and differences in care quality indicators. This information will fill an important gap in current knowledge, which has largely focused on higher-level structural variables such as nursing home size and ownership, or on individual employee variation in adherence to required elements of care. Findings may suggest approaches to task design that are likely to be associated with better worker and quality outcomes. The connections between task design, worker satisfaction and care quality are of interest in care settings beyond nursing homes, particularly in other care settings where care is increasingly provided by health care workers without extensive professional training.
Fiscal Year: 2001
Department: BOSTON UNIVERSITY CHARLES RIVER CAMPUS
Project Start: 09/30/2001 - **Project End:** 09/29/2003

Grant Number: R01 HS10606
PI Name: PHILLIPS, CHARLES
Project Title: ASSISTED LIVING AND HEALTH SYSTEM USE
Abstract: This research will examine how the characteristics of assisted living facilities (ALFs) affect the ways in which ALF residents interact with the health and long-term care systems, specifically their utilization of Medicare-covered health services and transitions to other care settings. One of the most dramatic expansions in long-term care services in the last decade has been the expansion in the role and supply of "assisted living," a residential setting that provides 24-hour supervision and some personal care services. The last five years have seen a dramatic expansion in State regulation and payment for assisted living, in no small measure because States believe ALFs can be a cost-effective alternative to nursing home care. Despite this hope, there is relatively little empirical information about the role ALFs play in meeting the needs of the frail elderly. In addition, there is no information about the effects of variations among ALF organizational features that may affect the degree to which residents use other health care services. Thus, the four specific aims of the proposed research are: Aim #1: To describe the ALF residents' health service utilization. Aim #2: To investigate the association between specific organizational characteristics of ALFs and residents' health service use. Aim #3: To describe the patterns of transitions in living arrangements experienced by ALF residents who leave assisted living. Aim #4: To investigate the association between residents' transitions to nursing homes and the organizational characteristics of ALFs. These issues will be investigated with data from the only nationally representative sample of ALFs, their staff, and their residents. The results of the proposed research should be of considerable interest to consumers, providers, policymakers at both the State and Federal levels, and to health services researchers.
Fiscal Year: 2000

Department: MENORAH PARK CTR FOR THE AGING MYERS RES
Project Start: 06/01/2000 - **Project End:** 05/31/2002

Grant Number: U18 HS13710
PI Name: POLAKOFF, DAVID
Project Title: Long Term Care Quality Improvement Partnership
Abstract: The AMDA Foundation proposes to develop a Long Term Care Quality Improvement Partnership that will enhance the quality of care and quality of life for the 1.6 million older adults who reside in the nation's 16,800 nursing facilities. The specific aims of the partnership during the next four years are to: 1) Create a national partnership of organizations involved in the quality of nursing home care that in turn will promote the formation of local partnerships. 2) Develop implementation toolkits for AMDA's evidence-based clinical practice guidelines (CPG) that relate to publicly reported quality measures. 3) Identify and train interdisciplinary educators and mentors in five states who will provide on-site implementation training for 10 nursing facilities (50 total). 4) Evaluate the impact of CPG implementation on process and outcome indicators in the 50 facilities. 5) Describe a set of model approaches to CPG implementation based on facility size and staffing, facility location and ownership, and facility case mix. 6) Disseminate the model approaches for implementation along with refined toolkits in both online and print versions. National partners include AMDA, AMDA Foundation, AIVIDA Foundation Research Network American Health Quality Association representing all quality improvement organizations (QIOs), major national nursing home trade associations, and representatives from key national long-term care professional associations. AMDA will build upon its already existing national and local relationships with most of these partners to promote culture change within the facilities that fosters a sustainable approach to implementing CPG guidelines. Partnering with the QIO community, AMDA will develop supporting material and approaches to implementation of three CPGs in phase I and at least three additional CPGs in phase II. In phase II, through partnership with the foundation's research network (a practice-based research network of 200 medical directors in 32 states) and the state QIO associations, we will select 50 pilot nursing homes to (a) receive more intensive CPG implementation onsite training, and (b) evaluate change in processes of care and outcomes as well as resource utilization. Throughout phase I and II, we will use the QIOs and other partners to disseminate material and lessons learned to all nursing homes throughout the country. Human subjects issue needs to be clarified - the applicant would need IRB approval for Phase 2.
Fiscal Year: 2002
Department: AMERICAN MEDICAL DIRECTORS ASSOCIATION
Project Start: 09/30/2002 - **Project End:** 09/29/2006

Grant Number: R03 HS11256
PI Name: QUILLIAM, BRIAN
Project Title: Secondary drug prevention of stroke in long-term care
Abstract: Secondary prevention of stroke has been demonstrated efficacious in numerous large-scale randomized clinical trials (RCT's). Despite the large number of RCT'S, few have included elderly people. This lack of research on secondary stroke prevention in the elderly seems to be paradoxical as the incidence of stroke increases with increasing age with some evidence of a worsening prognosis as well. As RCT's often exclude those at greatest risk, well-designed observational studies can complement RCT's by providing information to further understand both the beneficial, as well as unintended effects of secondary drug
prevention of stroke. Yet, confounding introduced by non-random allocation to drug treatment, defining of exposures when treatment may vary through time and bias introduced with informative censoring pose methodological challenges. In the nursing home setting these challenges are compounded since both within facility clustering of residents and the interrelation between organizational factors and hospitalizations occur.

The overall goal of this study is to quantify the beneficial and unintended effects of drug therapy used in

the secondary prevention of ischemic stroke in an elderly nursing home population. Of particular concern are the differences in treatment patterns and how they effect both mortality and rates of subsequent stroke. Using data collected from the Health Care Financing Administration (HCFA) Multistate Nursing Home Case-mix and Quality Demonstration Project, newly admitted nursing home residents in 5 states (ME, MS, KS, NY and SD) from the years 1992 to 1996 will be identified. Residents who are at least 65 years of age and have. had an ischemic stroke within the 90 days prior to admission will be eligible for inclusion.

The specific aims of this study are 1) to quantify the effects of antiplatelet therapy on the secondary prevention of ischemic stroke, 2) to determine the extent to which antiplatelet therapy increases the risk of unintended adverse effects and 3) to compare methods to analytically control for confounding in observational pharmacoepidemiology studies and further determine their differential effects on precision.
Fiscal Year: 2000
Department: BROWN UNIVERSITY
Project Start: 09/30/2000 - **Project End:** 09/29/2001

Grant Number: R01 HS11976
PI Name: ROSEN, JULES
Project Title: Organization Change to Improve Nursing Home Environment
Abstract: Approximately 1.56 million Americans over age 65 reside in nursing homes and 8% of our national health budget is spent on nursing home care. However, nursing homes are far from ideal in terms of the quality of care provided and the quality of life for residents. Although not always preventable, residents' injury and morbidity, such as pressure ulcers, injury from restraints and falls, malnutrition, dehydration and depression have been attributed, in large part, to the skill and motivation of the caregivers.

The proposed study will evaluate the impact of a global organizational intervention aimed at enhancing the ability as well as the motivation of all nursing home employees at two facilities in order to improve residents care and safety. Ability will be enhanced for all staff via a unique computer-based training program that provides a comprehensive curriculum of individual, self-paced education through Inter-active video documentaries. Motivation will be enhanced via a two pronged approach aimed at: (1) empowering employees using role structuring techniques developed following a TQM paradigm, and (2) changing employee attitudes by introducing them to market orientation techniques that enable them to balance the priorities of all constituents: self, resident and nursing home. This TQM process will require 18 months of active intervention.

Outcome measures will be obtained at quarterly and at bi-annually. Quality of care will be based on the Facility Quality of Care Index and frequency of resident complaints. Quality of We will be assessed with a new instrument that has been developed in a multi-center study. Staff outcomes will include objective data of injury rate, retention and days off work. Subjective staff measures will include the Job Satisfaction Scale and the Sheltered Care Environment Scale. Outcomes from the administrative perspective will include a "gap analysis which assesses how closely the desired goals of a program are achieved, as well as some financial markers of cost savings.
Fiscal Year: 2001
Department: UNIVERSITY OF PITTSBURGH AT PITTSBURGH
Project Start: 09/30/2001 - **Project End:** 09/29/2004

Grant Number: R03 HS11477
PI Name: RUSSELL, LOUISE
Project Title: Projecting Consequences of Better Hlth for Older Adults
Abstract: The Risk and Risk Factor Model is an established computerized simulation model that projects the consequences over time of changes in baseline risk factors, such as smoking, blood pressure, and diabetes. Based on data from the NHANES I Epidemiologic Follow-up Study (NHEFS), the model projects

all-cause mortality and hospitalization for the NHANES I cohort of adults, which is representative of the U.S. adult population in 1971-75. The proposed project will augment the model in two ways to make it suitable for projecting outcomes in a contemporary cohort of older adults.

(1) We will extract data from the NHANES III for adults 45-74 and adapt the model so that it can project mortality and hospitalization for this cohort. Fielded in 1988-94, the NHANES III is the most recent NHANES and better represents the current prevalence of risk factors in U.S. adults.

(2) We will address the problems that prevented the inclusion of nursing home admissions in the current Risk and Risk Factor Model and add this outcome to those projected by the model.

The augmented model will be capable of exploring the consequences over time for mortality, hospitalization, and nursing home admissions of changes in such risk factors as smoking habit, obesity, blood pressure, and chronic disease. Its projections can be used to examine the impact on middle-aged and older adults of important public health programs and goals, such as the Healthy People 2010 targets. The report for this project will present some illustrative projections.
Fiscal Year: 2001
Department: RUTGERS THE ST UNIV OF NJ NEW BRUNSWICK
Project Start: 06/01/2001 - **Project End:** 01/31/2003

Grant Number: R03 HS13005
PI Name: SAMBAMOORTHI, USHA
Project Title: Out-of-Pocket Prescribed Drug Costs Among Elderly Women
Abstract: Paying for prescription drugs is becoming a significant and growing problem for older Americans. Out-of-pocket prescription drugs (OOP-PD) spending places a disproportionate burden on older women, yet few studies have provided detailed and current information on the determinants of that burden. The present study estimates OOP-PD expenditures burden by women Medicare beneficiaries over age 65, using nationally representative data. OOP-PD burden will be measured in relation to income. The proposed project will explore patterns and correlates of OOP-PD burden among older women using longitudinal data from the multiple years of Medicare Current Beneficiary Survey (MCBS). The proposed project will estimate the proportion of elderly women with high OOP-PD burden and how health care access problems affect OOP-PD burden among subgroups of elderly women. The aims include: what were the trends in OOP-PD burden in a nationally representative sample of elderly women from 1992 through 1998? Was there a change in the predictors of high OOP-PD burden over time from 1992 through 1998? Among elderly women, who have been diagnosed with chronic conditions specific to women such as osteoporosis what factors predict high OOP-PD burden? And how do OOP-PD expenditures in MCBS compare with data from other nationally representative datasets such as Medical Expenditure Panel Survey (MEPS)? Examining the determinants of OOP-PD burden in this manner can assist policy-makers in understanding the sources of need for further assistance with evaluating alternative solutions to prescription drug issues.
Fiscal Year: 2002
Department: RUTGERS THE STATE UNIV OF NJ NEW BRUNSWICK

Project Start: 09/30/2002 - **Project End:** 09/29/2003
Grant Number: R01 HS12028
PI Name: SCOTT, JILL
Project Title: Nursing Home Working Conditions and Quality of Care
Abstract: Major concerns exist about the quality of care being delivered in the U.S. health care system in general and in the nursing home sector specifically. It has been suggested that working conditions such as staffing levels, the physical environment, workflow design, and organizational culture may effect the ability of health care workers to provide safe and effective care. Rapid growth in the number of older persons is expected to occur over the next 20-30 years, with approximately 5% of persons aged 65 years

and older residing in a nursing home at any one time. It is imperative that the factors associated with poor outcomes in nursing homes be better understood, so that appropriate quality improvement programs can be designed and successfully implemented. Nursing homes present a unique challenge in the consideration of organizational performance and how this performance may need to be improved. They are highly regulated, primarily for-profit, and staffed in large part by non-professionals. It is our belief that the' nursing home culture and the interactions that occur among nursing home staff play an important, if not vital, role in the ability of the nursing home to deliver high quality care. The purpose of this exploratory study is to describe selected working conditions ' in the nursing home and to determine what relationship these selected conditions have to nursing home performance. The specific aims of this study are: 1) determine the frequency and variability of selected working conditions (culture and environment, staff interaction, and staffing) among a sample of Colorado nursing homes; 2)-determine the frequency and variability of targeted organizational performance measures (MDS Quality Indicators, state survey citations and complaints filed with the state, and perceived effectiveness); 3) examine the relationship between selected working conditions and targeted organizational performance measures and; 4) elicit an in-depth description of organizational culture (rituals, heroes, celebrations) from key informants and explore their relationship to quality care. Data related to nursing home working conditions will be gathered via surveys of all nursing home staff, interviews of key informants, and using the Observable Indicators of Quality Scale. Performance measures will be collected using staff surveys of perceived effectiveness, quality indicators from the Minimum Data Set (MDS) Resident Assessment, state survey citations and complaints filed with the state. Thirty-six nursing homes will be selected for the study using a stratification process based on 3 MDS quality indicators.
Fiscal Year: 2001
Department: UNIVERSITY OF COLORADO HLTH SCIENCES CTR
Project Start: 09/30/2001 - **Project End:** 09/29/2004

Grant Number: R03 HS11709
PI Name: SHUGARMAN, LISA
Project Title: Urban/Rural Differences in Long-Term Care Utilization
Abstract: Elders with disabilities overwhelmingly prefer their own home to an institutional site of care. Partially in response to this preference, home and community-based services (HCBS) have expanded to meet the needs of elders with disabilities. However, elders in rural areas continue to use nursing homes at a higher rate than their urban counterparts. Little is known about the various influences on elders who access long-term care services and how the separate effects of need and access influence the use of such services. This study proposes to analyze a sample of admission assessments for two years (July 1999-July 2001) from administrative data based on the Minimum Data Set for Nursing Homes (MDS) and the Minimum Data Set for Home Care (MDS-HC) to assess urban/rural differences in the characteristics of admission cohorts of nursing home residents and HCBS recipients in Michigan. The content and large sample size afforded by these datasets permits cross-comparisons of elders using similar measures across sites of care and ensures sample sizes large enough to test potential interactions in multivariate analyses. Until now, the data necessary to do these analyses have not been available.
The proposed study will: (1) describe urban/rural differences in demographic and need characteristics of HCBS users; (2) describe urban/rural differences in demographic and need characteristics of nursing home users; (3) examine differences between HCBS and nursing home users within urban/rural boundaries; and (4) determine how differences in community resources influence access to long-term care services. This study will lay the groundwork for a future study on how access to HCBS influences outcomes of long-term care.
Fiscal Year: 2001
Department: RAND CORPORATION
Project Start: 09/30/2001 - **Project End:** 03/29/2004

Grant Number: R03 HS11276
PI Name: SILVER, HEIDI
Project Title: Family Carers' Response to Home Tube Fed Older Adults

Abstract: Home enteral nutrition, i.e., administration of liquid nutritional formula through a feeding tube into the gastrointestinal tract, is provided to older adults who are unable to ingest, digest or absorb adequate nutrients to meet their nutritional and metabolic requirements. The national cost of home enteral nutrition (HEN) is calculated at more than $800,000,000 with Medicare being the single largest payer. Increasing use of HEN in older adults combined with early hospital discharge and lack of insurance reimbursement for nutrition services has fostered reliance on family caregivers to manage HEN. Little is known of the impact HEN family caregiving has on older adult recipients nor on their caregivers.

This study aims to establish baseline data in a population of family caregivers and older adult HEN care recipients. In-home interviews with a minimum of 30 dyads will occur at one month and three months after hospital discharge on HEN. Care dyads' perspectives and professional assessment will be used to: (1) determine the unique responsibilities HEN family caregivers undertake; (2) evaluate the adequacy of training family caregivers have to manage HEN; (3) assess the impact HEN family caregiving has on each member of the care dyads' daily life, health, nutritional status and quality of life; and (4) assess changes in HEN family caregiving over time.

This data is useful to design and evaluate programs that will empower caregivers to provide Effective HEN management that restores older adults' nutritional status, health and functional independence. Effective caregiving may also prevent caregivers from suffering adverse health effects as a result of caregiving. Therefore, effective caregiving may preserve the structure of family caregiving by retaining older adults in the home environment and maintaining the future pool of unpaid family caregivers. It is estimated that family caregiving has a national economic value of $196,000,000,000.
Fiscal Year: 2000
Department: FLORIDA INTERNATIONAL UNIVERSITY
Project Start: 09/15/2000 - **Project End:** 02/15/2002

Grant Number: R03 HS09855
PI Name: SOUMERAI, STEPHEN
Project Title: EFFECTS OF DIFFERENTIAL COST SHARING IN THE ELDERLY
Abstract: The application for a focused-research project proposes to study the effects of reference pricing for certain anti-hypertensive drugs among people > age 65 in British Columbia. Under policy changes effective in early 1997, the government plan pays the cost of selected drugs within a therapeutic class, while patients are responsible for paying the additional cost of any more expensive drugs.
The policy excludes prescriptions by certain specialists and those for people with diabetes or asthma, and applies to ACE-inhibitors and calcium channel blockers, but not to several other classes that include anti-hypertensive drugs.

For the two years before and one year after the policy change, the study would compare changes in drug use for patients who were prescribed the affected anti-hypertensive with use for two other groups: patients prescribed a calcium channel blocker not subject to reference pricing, to control for changes in use within the same therapeutic class, and patients treated with the affected drugs in the neighboring province of Saskatchewan, to control for time trends in anti-hypertensive drug use that were not affected by payment policy changes.
The control groups will be matched by age, gender, and economic status. The investigators would use segmented linear regression to estimate changes in level and trend of use rates before and after the policy change.
Fiscal Year: 1999
Department: HARVARD UNIVERSITY (SCH OF PUBLIC HLTH)
Project Start: 09/01/1999 - **Project End:** 08/31/2001

Grant Number: R01 HS10336
PI Name: TENO, JOAN

Project Title: RESIDENT ASSESSMENT OF PAIN MANAGEMENT (RAPM)
Abstract: Frail, older persons residing in nursing homes are a vulnerable population. Often, these patients are disabled, cognitively impaired, and financially impoverished. Nationally, one in five persons dies in a nursing home. Research has shown that between 33% and 83% of patients have ongoing pain that impairs mobility, results in depression, and diminishes quality of life. A recent study from the Center for Gerontology and Health Care Research at Brown University reported that one in four of cancer patients discharged from an acute care hospital who were assessed to be in daily pain was not administered any analgesic medicine The observed high rates of unrelieved pain are not based on a scientific controversy regarding pharmacological management. They are not based on patient preferences. Educational interventions and professional guidelines have not remedied this situation-far too many persons are still not receiving adequate palliation.

An important step to improving the quality of care is raising health care providers' awareness of the opportunity to improve. The overall goal of this project is to develop and validate an efficient measurement strategy for accountability and quality improvement of pain management in nursing homes.

Potential sources of data include interviews with nursing home residents or a surrogate in the case of nursing home residents with severe dementia and the computerized Minimum Data Set (MDS). We propose to develop and validate a brief, survey of nursing home residents or their loved ones concerning the quality of pain management through focus groups, cognitive interviews, and conducting tests of reliability and construct validity (Specific Aim I a). Interviews with the patient or family will utilize the methodology of Patient-Centered Reports as applied in the Consumer Assessment of Health Plan Study. Because of the high burden of cognitive impairment in nursing home residents, we will examine the validity and potential bias of relying on a surrogate to examine the quality of pain management (Specific Aim II).While MDS pain assessment instrument reliability has been examined with trained research nurses, a third effort will examine the reliability and validity of the MDS in its "real world" application (Specific Aim I b). Based on the collected information on reliability, validity, and case of data collection, we will formulate an efficient and valid strategy to examine the quality of pain management for frail, older persons residing in nursing homes. Qualitative reviews include focus group discussions, expert panel review of proposed instruments, and cognitive testing. The latter involves carefully interviewing individuals regarding their response processes. Quantitative analyses include testing intra-rater reliability using the kappa statistic to identify agreement between tests separated in time. The investigators will test validity by comparing the correlation between the number of problem areas detected by their instrument and various independent measures including: 1) the patient's pain intensity measured by the nurse, 2) the pain management index, 3) pain documentation, 4) a registered nurse's assessment of the quality of pain management.
Fiscal Year: 2000
Department: BROWN UNIVERSITY
Project Start: 09/30/2000 - **Project End:** 08/31/2003

Grant Number: R18 HS11869
PI Name: TEIGLAND, CHRISTIE
Project Title: Using Prospective MDS Data to Enhance Resident Safety
Abstract: The goal of the proposed research is to determine whether preventable adverse outcomes for the frail elderly population in long term care settings can be reduced by providing prospective computerized information alerting nursing and other staff to the likelihood of the problem occurring, and further providing resident specific risk factors likely to cause the adverse outcome so that preventive actions can be taken. Through the use of prospective clinical data, we hope to shift the focus from using Minimum Data Set (MDS) assessment data for investigating adverse outcomes after they occur, to one centering on the safety of individual residents before an adverse event occurs. We plan to test three specific outcomes of care that are directly related to patient safety and are known to be preventable adverse events -- falls, pressure ulcers and urinary tract infections (UTIs). These clinical outcomes represent major socio-economic problems in health care. The specific aims of the project are to: (1) Support the use of clinical informatics by 'front line' staff that are in daily contact with residents. (2) Utilize predictive logistic regression models that identify the critical risk factors and calculate the likelihood of an adverse outcome

occurring with a high degree of accuracy. (3) Encourage the day-to-day use of targeted clinical information through development of a web based application that will flag residents by predicted probability of the event occurring--high, moderate or low--and report the residents' risk factors based on the most recent assessment data so that interventions can be initiated before a negative outcome occurs, thereby improving the processes and outcomes of care. (4) Test the feasibility of accessing the web based application using 'bedside' electronic technology vs. hard copy reports. (5) Educate nursing staff about how to use the technology. (6) Conduct special training aimed at providing a basic understanding of the relevance and practical application of statistical and clinical information in avoiding errors and improving resident safety, (7) Measure statistically significant improvements in facility rates for the adverse outcomes following implementation of the information. (8) Identify 'best practices' in implementing the use of clinical informatics, as well as barriers to implementation. (9) Extend the collection and use of this data to the entire continuum of long term care providers.
Fiscal Year: 2001
Department: FOUNDATION FOR LONG TERM CARE
Project Start: 09/30/2001 - **Project End:** 03/31/2005

Grant Number: R01 HS11990
PI Name: TRINKOFF, ALISON
Project Title: Organization influence both patient and worker safety
Abstract: Several recent reports have highlighted growing concerns about the quality of patient care in the U.S. (IOM, 2001; Kizer, 2000; Kohn, Corrigan & Donaldson, 2000; Schuster et al., 1998). While these concerns are not new, there is a perception that the quality of patient care is decreasing. At the same time, injuries to health care workers remain a serious problem. As it is likely that reductions in staffing and other organizational changes may act as risk factors for adverse outcomes for both patients and worker□, patient and worker outc6mes will be linked by institution to address this crucial hypothesis. To do this, patient and worker injury rates in both acute and long term care facilities will be assessed with an ecological framework, measured over time, using the following specific aims: 1) Examine the relationship of adverse patient outcomes (post-surgical complications, post-surgical misadventures) to staffing variables (staffing, skill mix, RN to total) at the institutional level; 2) Examine the relationship of adverse worker outcomes (worker injuries) to staffing variables at the institutional level; 3) Identify changes in the rate of adverse patient outcomes in relation to staffing variables by institution, over time (1998-00); 4) Identify changes in the rate of adverse worker outcomes in relation to staffing variables by institution, over time (1998-00); and 5) Examine the organizational characteristics of hospitals and nursing homes in relation to rates of adverse patient and worker outcomes. Three years of administrative data (1998-2000) will be compiled from three states using acute care hospitals and nursing homes. Acute care adverse patient outcomes will come from the HCUP QI and for nursing homes from the HCFA Minimum Data Set. Organizational descriptors will be obtained from the AHA Annual Survey database (e.g. total FTEs, RN FTE, nonprofit status, and size) and OSCAR (beds, special services, and staffing). Worker injuries will be obtained from state First Report of Injury databases. Longitudinal trends over three years will be examined, using (Generalized Estimating Equations, in addition to cross-sectional analyses. This study will provide empirical data to support the utility of modifications in the organization of health systems, which are designed to have the quality and safety of patient care while maximizing the health and productivity of workers.
Fiscal Year: 2001
Department: UNIVERSITY OF MARYLAND BALT PROF SCHOOL
Project Start: 09/30/2001 - **Project End:** 09/29/2004

Grant Number: R13 HS10974
PI Name: VILLANI, PATRICIA
Project Title: TOWARD EXCELLENCE IN HOSPICE & PALLIATIVE CARE IN MCOS
Abstract: In March 2000, the American Hospice Foundation (AHF) conducted a conference, Toward Excellence in Hospice and Palliative Care in Managed Care Organizations that brought together 70 prominent leaders from MCOs large employers, and hospice organizations. The specific aims of the second

annual "dissemination conference," planned for November 7-8, 2001, at the Cosos Club in Washington, D.C., are to:

- Document and present effective models of end-of-life care in managed care organizations.
- Foster partnerships to ensure rapid adaptation, replication, and dissemination of effective models.
- Collaborate on the development of a template for end-of-life care guidelines for managed care organizations.

Among the MCOs that will be represented are: United HealthCare, Aetna U.S. Healthcare, Pacific are Health Systems, Sierra Health Services, Kaiser Permanente, Trigon BC/BS, Harvard Vanguard, Group Health Incorporated, as well as the American Association of Health Plans. These insurers will confer with providers and purchasers about services for dying patients and their families, develop partnerships, discuss ways to implement innovative models, and build the capacity for participation in research activities discussed at the event.

Based on recommendations made in the first conference, the evening and one-day program will include the following topics: effective hospice referral programs in MCOs, a model MCO-based physician education program, a model case management training program, and end-of-life guidelines for disease management protocols. It is anticipated that the results will include the publication of conference proceedings on the Web, publication of articles in several national newsletters, development of new research protocols, establishment of new partnerships, and implementation of models in a variety of managed care environments.
Fiscal Year: 2001
Department: AMERICAN HOSPICE FOUNDATION
Project Start: 09/30/2001 - **Project End:** 09/29/2002

Grant Number: U18 HS11064
PI Name: WATSON, NANCY
Project Title: A MODEL FOR USE OF THE UI GUIDELINE IN US NURSING HOMES
Abstract: This study will test the effectiveness of a new model of care to translate the AHCPR Urinary Incontinence (UI) Guideline into practice in nursing homes. The model will utilize nurse practitioners in nursing homes to implement a carefully designed and focused effort to identify, work up, treat and follow up new cases of urinary incontinence on an ongoing basis -- in collaboration with medical and nursing staff. The model will be tested utilizing existing nurse practitioners in nursing homes, but has potential application for all nursing homes -- regardless of whether they have nurse practitioners on staff -- since the nurse practitioners' work could be effectively accomplished by consulting nurse practitioners and could likely be reimbursed under existing HCFA mechanisms. A quasi-experimental design will be used to evaluate the practice performance of five experimental nurse practitioners at experimental nursing home sites and five control nurse practitioners at control nursing home sites
who will be followed prospectively for 15 months prior to the intervention and 15 months during the intervention using detailed chart review by blind nurse reviewers. A total of 200 cases of new UI prior to the intervention and 200 cases of new UI during the intervention will allow comparison of changes or lack of changes in key practice performance areas. The study will determine the feasibility of this focused approach by nurse practitioners for improving specifically targeted areas of UI care in nursing homes (i.e., case identification, treatment of reversible causes of UI, basic physical examination, rectal examination, post-void residual testing, bladder training, use of recommended UI medications) as well as the effectiveness of the model in reducing UI in nursing homes, preventing the complications associated with UI and improving the quality of life of nursing home residents and families. The cost of the model will also be determined and compared to usual care.
Fiscal Year: 2000
Department: UNIVERSITY OF ROCHESTER
Project Start: 09/01/2000 - **Project End:** 08/31/2004

Grant Number: R03 HS10794
PI Name: WEINER, ANDREA
Project Title: EFFECT OF FORMAL HOME CARE SERVICES ON CAREGIVER BURDEN
Abstract: This proposal addresses providing a better understanding of the dynamics of family Caregiving to low income and frail elderly individuals living in the community as well as to test the ability of a program enrolling Medicare- and Medicaid-eligible individuals to support the role of informal care. The proposed research will accomplish these objectives within the context of the Minnesota Senior Health Options (MSHO) program1 a Medicare- and Medicaid-capitated, integrated health care program for seniors who are "dually-eligible" (i.e. eligible for Medicare based on their age and eligible for Medicaid based on their socioeconomic status).

This study uses data from a survey of home and community based MSHO enrollees and two sets of matched controls not enrolled in MSHO to examine the following specific objectives: 1) To test whether coverage of dual eligible individuals through the MSHO program reduces family caregiver burden, in comparison to those not enrolled in MSHO. 2) To determine if family caregiver burden decreases with increased amount and frequency of home care services, including home health care services, and whether increased skill level of the formal home care provider will result in lower levels of caregiver burden. 3) To determine whether formal care use decreases family caregiver burden for patients in the MSHO and non-MSHO groups, and whether the impact of MSHO on family caregiver burden is a function of formal care use.

To address these research aims, the Principal Investigator will use a social support conceptual framework to examine how community and home care services moderate the effect of stressors such as care recipient impairment on caregiver burden. Ordinary least squares regression and structural equation modeling will be used to carry out the analyses.

Minnesota Senior Health Options (MSHO) began in February 1997. Services are provided through three health plans and a network of care systems and providers. The demonstration program was offered in four counties initially and is currently expanding to additional counties in the metropolitan Twin Cities area. Enrollment in the program is voluntary. The proposed study will use data from dual-eligible individuals living in the community and their family members.

A subset of three surveys from the main evaluation of MISHO will be used for this study. The survey instruments collect data for four purposes: 1) verification of information obtained from secondary data sources; 2) explanatory variables to be used in analyses of outcomes; 3) provide outcome measures (e.g. satisfaction); and 4) classification of enrollees by health and/or functional status to be used for case mix adjustments.
Fiscal Year: 2000
Department: UNIVERSITY OF MINNESOTA TWIN CITIES
Project Start: 06/15/2000 - **Project End:** 09/30/2001

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CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL

CDC's National Center for Injury Prevention and Control (NCIPC) is involved in a wide array of activities to promote enhanced mobility and independent living among older Americans by preventing injuries and injury-related disabilities. The Injury Center's research and programmatic efforts that target older Americans focus preventing falls, understanding issues affecting older drivers, and preventing elder abuse. CDC supports the National Resource Center on Safe Aging, an organization that focuses broadly on unintentional injury prevention among older Americans:

- CDC funds the National Resource Center on Safe Aging (NRCSA), a joint effort between the Center on Aging at San Diego State University and the American Society on Aging, to provide information about preventing injuries among older adults to **public health professionals, senior service providers, and others** through an interactive web site (www.safeaging.org). NRCSA provides information about both intentional and unintentional injuries. Falls, pedestrian injuries, fires, and elder abuse and neglect are focus areas.

Falls Prevention

Falls are the leading cause of injuries and disabilities among persons aged 65 and older. **Up to 40% of people age 65 and older fall each year, and 20% to 30% of those who fall suffer serious injuries such as fractures or head traumas that reduce mobility and independence, and increase the risk of early death.** In 2001, 10,300 older adults died and 1.6 million were treated in emergency departments for fall-related injuries. Hip fractures are the most serious fall-related fracture. In 2000, there were 319,400 hospital admissions for hip fractures. About 20% of hip fracture patients die within one year following their injury and many other never regain their former level of function. Only half of all older adults who were living independently before their fracture are able to live on their own a year later.

Falls are the leading cause of traumatic brain injury (TBI) among older adults (aged 65 years and older) in the United States. Approximately 64,000 fall-related TBIs occur annually; that is, each day an estimated 175 older Americans sustain a fall-related TBI. Of these, 11 die and 44 are hospitalized because of their injuries. Among older adults, the annual cost of TBI-related hospitalizations alone is 3.3 billion dollars. With the expected aging of the U.S. population, the importance of TBI as a public health problem will increase dramatically in the coming years.

Disseminating What Works
CDC researchers have developed *The Tool Kit to Prevent Senior Falls*, a comprehensive collection of fall prevention materials for health professionals. The *Tool Kit*, originally published in 1999, contains fact sheets, health education materials, and a home assessment checklist designed to reduce falls and related injuries among older adults. Materials are based on the published literature and research conducted and sponsored by CDC since the late 1980s. The

Tool Kit materials, in both English and Spanish, are currently available online. More than 6,000 recipients have requested the *Tool Kit* for fall prevention programs. *Tool Kit* materials have been distributed to clients at senior centers, hospitals, and health departments. The materials have also been used in professional presentations and for teaching nursing and health care students.

Published by CDC in 2000, *U.S. Fall Prevention Programs for Seniors: Selected Programs Using Home Assessment and Modification* **describes 18 fall prevention programs in 12 states. The book, available online, includes a description of the population** the program serves, a summary of the program, its strengths and weaknesses, program materials, funding source, and contact information. The book also includes contact information for 22 additional programs. While these programs are diverse, all use comprehensive education and fall-risk reduction strategies including home assessment and home modification. An appendix provides examples of materials such as educational brochures and home safety checklists that can serve as models.

Falls Prevention Programs

In FY 2002, CDC funded the California State Health Department to study the effectiveness of "No More Falls!", a community-based fall prevention program for independently-living older adults. The overall goal of this study is to demonstrate the effectiveness of a fall prevention intervention that is integrated into an existing community-based public health program for older adults. The study has been implemented among 552 seniors attending Preventive Health Care for the Aging clinics in two counties: urban San Diego county and rural Humboldt county. The intervention includes four elements: education about fall risk factors, exercise to increase strength and balance, medication review, and home assessment and modification. The goal of the intervention is to reduce incidence of falls requiring hospitalization by 10%. Results of the study, which is expected to be completed by October 2004, will help guide future efforts to develop multifaceted fall prevention programs.

In FY 2002, CDC funded state health departments in Arkansas, Maryland, Minnesota, North Carolina, and Virginia to implement and evaluate a program to teach older adults how to prevent fires and falls. *Remembering When: A Fire and Fall Prevention Program for Older Adults* is a curriculum developed by the National Fire Protection Association, CDC, the U.S. Consumer Product Safety Commission, and other partners. This program uses lesson plans, brochures, fact sheets, game cards, and other educational materials to present 16 life-saving lessons developed for older adults. It is the first program of its kind to educate older adults about both fire- and fall-related injury prevention, and is one of the few off-the-shelf programs available for communities to use for this purpose. To date, 382 group presentations and 457 individual presentations have been conducted; and 3245 alarms have been installed. In August 2002, Georgia State University was awarded to perform an in-depth evaluation of the effectiveness of this program to assess its ability to improve the knowledge and skills of older adults to prevent fires and falls. Evaluation results will be used by CDC to make informed decisions about future support and how to disseminate the program.

In addition, CDC began funding two state health departments in FY 2002, the Michigan Department of Community Health and the Washington State Department of Health, to address falls among older adults.

- The Michigan Department of Community Health is developing, implementing, and evaluating hospital-based geriatric fall prevention clinics. The project goals are: 1) to develop a fall prevention training program; 2) to improve ED provider skills and clinical pathways; 3) to develop a model hospital-based geriatric fall prevention clinic; and 4) to reduce all fall risk factors among older adults. It is hoped that the insights and lessons learned from this project will assist in future deployment of the hospital-based geriatric fall prevention model.
- The Washington State Department of Health is implementing and evaluating a fall prevention program (that includes exercise and referrals for medical care management and education) in three settings and is developing a best practices model to be used throughout the state and nationwide. This intervention follows a community medical model, which weaves together skills and resources of public health, social service agencies, and health care providers. Program staff will conduct a systematic evaluation to determine the impact and outcomes of the targeted intervention activities. It is hoped that the findings from this program will assist in the development of guidelines for implementing this type program using existing community-based resources.

Gathering Better Data on Falls

In order to understand more about fall-related risk factors and how falls occur (e.g, circumstances, predisposing and enabling factors, especially for population subgroups such as the oldest old and minorities), CDC is supporting the expansion of the National Electronic Injury Surveillance System of the Consumer Product Safety Commission to collect information about fall injuries from hospital emergency departments. CDC is also funding the 2nd Injury Control And Risk Survey, a national injury survey that will include information about the prevalence of falls and fall prevention behaviors among seniors.

Research on Falls Prevention

CDC conducts research by CDC scientists, and through a peer-reviewed, investigator-initiated grants program in universities and other research institutions across the country.

In a study using National Hospital Discharge Survey data, CDC analyzed hip fracture hospitalization rates between 1988 and 1996, and found that rates for older women increased 40% while the rates for men remained stable. Of the 340,00 hospitalizations for hip fracture in 1996, 80% occurred among women.

While we know that multi-component interventions have been successful in reducing falls among high-risk older adults, few studies have addressed how such approaches can be practically and effectively applied within existing community structures. In FY 2002, CDC began funding the Wisconsin Department of Health, in collaboration with the University of Wisconsin, to conduct a randomized controlled trial to assess the effectiveness of a comprehensive approach to

preventing falls among adults ages 65 and older at high risk for falls. This project will use two complementary strategies: a comprehensive at-home assessment followed by individualized risk reduction strategies, and a broad-based program to engage and educate service agencies and health providers.

The intervention involves two components: identifying predisposing fall risk factors through a comprehensive assessment, and facilitating risk reduction through changes in medical condition, vision, medications, behavior, physical functioning, home environment, and social support. The intervention will include participation in existing exercise classes that have been certified by the project, and will also link participants to existing medical care and human service networks. After one year, the intervention group is expected to show a 40% decrease in fall rates. Other expected outcomes include decreased hospital and nursing home stays, improved physical function, and a decreased fear of falling. The study is expected to be completed in August 2005.

Previous extramural research (peer-reviewed, investigator-initiated grants) on reducing falls in nursing homes has shown promising results in reducing falls by as much as 19 percent. Building on these results, researchers have conducted a randomized controlled trial to test the effectiveness of the Tennessee Fall Prevention Program, a statewide effort to train nursing home staff about safety practices that can prevent falls among residents. If this program is effective, it will provide a model for cost-effective injury prevention programs in long-term care facilities.

Extramural research grants funded in FY 2001 and FY 2002 were the following:

- Project Title: *"Biomechanics of Injury Prevention During Falls"*
  Project Director: Stephen Robinovitch, Ph.D.
  Institution: San Francisco General Hospital; Biomechanics Research Laboratory; San Francisco, California

Considerable evidence now exists that fall severity, as defined by the configuration and velocity of the body at impact, is a stronger predictor than bone density of hip fracture risk. Data also suggest that specific protective responses exist for reducing fall severity and fracture risk, including braking the fall with the outstretched hands, and absorbing energy in the lower extremity muscles during descent. This study is designed to better define the biomechanical and neuromuscular variables that govern safe landing during a fall, and to identify the neuromuscular variables governing the efficacy of the protective responses as the basis exists for designing exercise-based interventions for reducing hip fractures in the elderly and other fall-related injuries.

- Project Title: *"Biomechanics of Injury Prevention During Falls"*
  Project Director: Walter Short H., M.D.
  Institution: SUNY Health Science Center; Department of Orthopedic Surgery; Syracuse, New York

Data suggest that specific protective responses exist for reducing fall severity and fracture risk. These include breaking the fall with the outstretched hands and absorbing energy in the lower

extremity muscles during descent. However, no study has directly compared these responses in the young and elderly, or identified the neuromuscular variables governing the efficacy of these responses. Accordingly, little basis exists for the design of exercise-based interventions for reducing hip fractures in the elderly. This project seeks to understand these questions.

Older Drivers

In 2000, 7,529 people 65 years and older died in motor vehicle crashes. People 65 years and older represented 13 percent of the population in 2000 and 17 percent of motor vehicle deaths. The 65-and-older age group is the fastest growing segment of the population. By 2030, elderly people are expected to represent 20 percent of the population. Elderly people are more susceptible than younger people to injury and death following motor vehicle injuries.

Identifying the Severity of Problem and the Risk Factors Involved
CDC has analyzed fatal and nonfatal injury data to assess trends over time in motor vehicle-related deaths to older persons. The rate of both fatal and nonfatal motor vehicle-related injury increased during the study period. Rates increased as age increased, and men had rates twice as high as women. CDC collaborated with the University of California, San Diego to explore why older drivers stop driving. This study found that medical conditions were the most commonly given reason for stopping, and vision loss was the most common problem.

CDC also conducts research through peer-reviewed, investigator-initiated grants program in universities and research institutions across the country. In FY 2001 and FY 2002, the following extramural research grant related to older drivers was funded:

- Project Title: *"Motor Vehicle Crashes Among the Elderly"*
  Project Director: Maria Segui-Gomez, M.D., Sc.D.
  Institution: Johns Hopkins University; School of Public Health; Baltimore, Maryland

This study measures outcomes and crash-related problems one year after injury; identifies factors that predict poorer outcomes; and compares the prevalence of problems among elderly MV crash victims, the general elderly population, and other injury victims.

Elder Abuse

Abuse of elderly persons is on the rise in the U.S. In 1996, the National Elder Abuse Incidence Study reported 550,000 incidents of abuse among elderly persons. There are no federal requirements for elderly protective services, nor are there regulations on training staff who provide protective services or for those investigating alleged cases of elder abuse. State protective services for the elderly vary widely; some are merged with children's services while others are separate.

Research on Elder Abuse

In FY 2001 and FY 2002, CDC's NCIPC and Public Health Practice Program Office awarded a grant to the University of Iowa to evaluate the implementation and impact of state adult protective service statutes and regulations on the conduct of elder abuse investigations and outcomes. This study found that states that require mandatory reporting of elder abuse and that closely track the number of these reports have higher investigation rates. Additionally, there are substantial differences among the states in the extent to which they investigate and are thus able to substantiate elder abuse cases. This difference is partially attributed to variations in state statutory requirements for mandatory reporting of elder mistreatment. Thus, to better address the growing public health concern of elder abuse, there is need to improve data collection at the state level.

NATIONAL CENTER FOR INFECTIOUS DISEASES

Infectious diseases remain a serious problem in the U.S. Pneumonia and influenza remain the sixth leading cause of death in the United States and septicemia has risen dramatically during the past three decades to become the 11th leading cause of death. Chronic liver disease, a substantial proportion of which is due to hepatitis C virus, is the 10th leading cause of death in the U.S. Pneumonia and septicemia are also contributing and precipitating factors in the deaths of many Americans with other illnesses, especially cardiovascular diseases, cancer, and diabetes. Infectious diseases have a disproportionate impact on older Americans, 65 years old and older. Quality of life also declines for millions of older Americans as a result of infectious illnesses. Prevention and control of infectious diseases will enhance and lengthen the lives of older Americans, make them more productive, and reduce associated medical costs.

CDC emphasizes surveillance and training to prevent and control hospital-acquired and other institutionally acquired infections in elderly patients. Additionally, CDC staff provides education regarding infection control to care providers at nursing home and patient care conferences. This education focuses on patient care treatment and procedures associated with the highest risk of infection. Through the National Nosocomial Infections Surveillance (NNIS) system, special infection risks of elderly patients have been identified. According to NNIS, over half of the hospital-acquired infections occur in elderly patients, although these patients represent about one-third of all discharges from hospitals. The use of certain devices, such as urinary catheters, central lines, and ventilators, are associated with high risk of infection in all types of patients. In elderly patients, the risk of infection is high even when a device is not used, suggesting that infection control must address other risk factors such as lack of mobility and poor nutrition, in addition to device use.

Monitoring Influenza

Although delivering the influenza vaccine to persons at risk is a critical step in preventing illness and death from influenza, immunization is only part of the prevention equation. Other CDC efforts to combat influenza in the elderly include: (1) improving domestic surveillance through the sentinel and state health department laboratory surveillance networks; (2) conducting

surveillance for influenza viruses in the U.S. and increasing surveillance of influenza in the People's Republic of China and other countries in the Pacific Basin so the virus strains in the influenza vaccine can be updated each year ; (3) conducting studies to better define the immunological response of the elderly to influenza vaccines and to natural infection; (4) conducting immunological studies involving laboratory and clinical evaluation of inactivated and live attenuated influenza vaccines in an effort to identify improved vaccine candidates; (5) improving methodologies for rapid viral diagnosis; (6) using recombinant DNA techniques to develop influenza vaccines that may protect against a wider spectrum of antigenic variants; and (7) providing laboratory training in the People's Republic of China, other Pacific Basin countries, and Latin America to develop and expand capacity for the diagnosis and detection of antigenic changes in the virus.

Preventing Pneumococcal Disease

Prevention of pneumococcal disease in the elderly requires widespread application of effective immunization. New data from CDC's Active Bacterial Core Surveillance, a component of the Emerging Infections Program, indicate that disease rates are dropping in the elderly as a result of providing the new pneumococcal conjugate vaccine to children. Disease rates remain high in elderly persons, however, and giving pneumococcal vaccines to this age group remains important. CDC is working to improve use of the currently-available pneumococcal polysaccharide vaccine and is helping to evaluate possible new vaccines, such as conjugate and common protein antigen vaccines, for the elderly. These measures are critical to decrease illness and death from pneumococcal infections in the elderly. The elderly are also at high risk for disease due to drug-resistant pneumococcal strains; through the ABCs system, CDC is monitoring the spread of drug-resistant pneumococcal strains and evaluating factors contributing to resistant infections.

Other Respiratory Infections

Recent studies have suggested that noninfluenza viruses such as respiratory syncytial virus and the parainfluenza viruses may be responsible for as much as 15 % of serious lower respiratory tract infections in the elderly. These infections can cause outbreaks that may be controlled by infection control measures and treated with antiviral drugs. It is important to define the role of these viruses and risk factors for these infections among the elderly. CDC is working to define the disease burden associated with respiratory syncytial virus and parainfluenza virus infections in the elderly and helping to develop vaccination strategies for respiratory syncytial virus.

Healthcare-acquired Infections and Adverse Health Events

The Institute of Medicine (IOM) has reported that preventable adverse events associated with healthcare, including healthcare-acquired infections, result in 98,000 deaths and $29 billion in additional healthcare costs annually. Overall, 3-4% of all patients suffered a healthcare related adverse event. The elderly are disproportionately affected by such adverse events.

Existing technology and knowledge can prevent many adverse events but prevention strategies have not been widely and successfully implemented. However, some successes have occurred. For example in 2000, CDC reported that bloodstream infections among patients in U.S. intensive care units, most of whom are elderly, declined by 32% to 43% during the 1990's (MMWR 2000:49;149-153). This success is due to improved efforts in infection control in U.S. hospitals, to technological advances, and to improved patient care . CDC is embarking on a 5 year plan to substantially reduce bloodstream infections in other healthcare settings such as cancer and dialysis centers, respiratory infections in long term care patients, infections following surgery, and infections due to antimicrobial resistant organisms. CDC has increased its focus on the use of new information technologies to improve efficiency, developed new collaborations with both private sector partners and public sector partners, and expanded its work in non-hospital settings (long-term care, home health care, cancer centers, dialysis centers) where a substantial portion of healthcare for the elderly is provided. Regarding antimicrobial resistance, CDC, through the Campaign to Prevent Antimicrobial Resistance in Healthcare Settings (http://www.cdc.gov/drugresistance/healthcare) Is promoting strategies for clinicians to use to prevent antimicrobial resistance in many healthcare settings for the elderly (e.g., hospitals, dialysis centers, long-term care facilities).

Group B Streptococcus Disease

Group B streptococcus (GBS) is a major cause of invasive bacterial disease in elderly persons in the U.S. To document the magnitude of GBS disease in the elderly and develop preventive measures, CDC established population-based surveillance for GBS disease and case control studies to identify risk factors. An analysis of active surveillance data from 1993-1998 that was published in the *New England Journal of Medicine* in 2000 showed that the incidence of disease in adults $\geq$ 65 years old in 1998 was 20.1/100,000 population and the case fatality ratio was 15% compared to 8% in adults 15-64 years old. Consistent with findings from earlier surveillance, the incidence of disease in black adults was approximately twice that in non-black adults. These data, along with serotype data on adult invasive GBS isolates, will be utilized to develop and evaluate vaccines and to promote the prevention and treatment of GBS disease in the elderly population.

Foodborne disease

Foodborne disease is of particular concern in the elderly, who typically can have higher illness and death rates from foodborne pathogens than younger persons. Of particular concern are Salmonella enteritidis infections, often caused by undercooked eggs, and *Escherichia coli* O157:H7 infections, often caused by undercooked hamburger. CDC is working with USDA and FDA to encourage use of pasteurized eggs in nursing homes and thorough cooking of hamburger meat.

Listeriosis is a severe bacterial foodborne infection that particularly affects the elderly, as well as pregnant women and immunocompromised person. CDC is participating in the interagency federal control plan for listeriosis, that includes enhanced surveillance, investigation of sporadic cases and of outbreaks to determine the sources, so that control measures can be targeted, and increased efforts to educate persons at higher risk in prevention measures.

Preventing Legionnaires' Disease

An estimated 8,000 - 18,000 cases of Legionnaires' disease occur each year in the United States. Legionnaires' disease is a severe form of pneumonia caused by the bacterium, *Legionella spp.* Between 5%-30% of persons contracting Legionnaires' disease die depending on underlying risk factors. The elderly, particularly those with underlying chronic diseases, are at greatest risk. Although attack rates are low, legionnaires' disease can be transmitted when susceptible persons are exposed to mists that come from a water source (e.g., air conditioning cooling towers, whirlpool spas, showers) contaminated with Legionella bacteria. Novel prevention strategies are focusing on the use of new disinfectants in water systems that may have the potential for greatly reducing the occurrence of legionnaires' disease. In addition, CDC is developing improved surveillance systems to more quickly identify outbreaks.

Gastrointestinal Disease
Studies using information from national data bases show that of all age groups, the elderly (≥70 years old) have the highest rates of hospitalizations and deaths associated with diarrhea in the United States. In the elderly, caliciviruses (also called Norwalk-like viruses or Small Round Structured Viruses) are likely to be the most common cause of both epidemics and sporadic hospitalizations for acute gastroenteritis and studies needed to confirm this hypothesis are now underway. These studies should lead to a better understanding of ways to prevent gastrointestinal disease in the elderly. The recent identification of rotavirus as a cause of epidemic diarrhea in the elderly suggests that one approach to control may involve use of vaccines currently used for young children. Further study is now needed to determine the importance of rotavirus to gastrointestinal disease in the elderly.

Other Infectious Diseases
It is becoming increasingly evident that infections play a major role in causing or contributing to some chronic diseases. Some of these conditions result from infection acquired at a younger age (including liver cancer and cirrhosis related to chronic hepatitis B or hepatitis C, stomach and duodenal ulcers or gastric cancer from *Helicobacter pylori*), while others develop from exposures later in life. CDC is actively promoting and pursuing ways to prevent initial infection and the chronic consequences of such infections. Microbes are also suspected but not yet proven as triggers of still other chronic conditions. CDC is developing research activities that identify and define these relationships. The potential to use infection control in the prevention or treatment of infections that produce chronic disease can improve the quality and length of life for many elderly persons.

NATIONAL IMMUNIZATION PROGRAM

CDC's National Immunization Program provides medical and epidemiologic expertise and collaborates with other CDC organizations and HHS agencies in developing strategies to enhance immunization coverage among adults, including influenza, pneumococcal, hepatitis B, measles, mumps, rubella, and varicella vaccines and combined tetanus and diphtheria toxoids. One of the greatest public health challenges is extending the success in childhood immunization to the adult population. The burden of vaccine-preventable diseases in adults in the U.S. is staggering – approximately 46,000 to 48,000 adults die each year from vaccine-preventable diseases.

Despite the progress that has been made, adult vaccines continue to be underutilized. Reasons for this include: 1) limited appreciation of the impact of adult vaccine-preventable diseases and missed opportunities to vaccinate during contacts with health-care providers; 2) failure to organize programs in medical settings that ensure adults are offered the vaccines they need; 3) doubts about the safety and efficacy of adult vaccines; 4) selective rather than universal approaches to vaccination; and 5) inadequate reimbursement for adult vaccination services.

To address these challenges, CDC has taken a number of steps, including:

Tools for Supporting Adult Immunization Practices
Enhancing education and training is a priority in adult vaccination efforts. In 2002, the first version of the Adult Clinic Assessment Software Application (ACASA) was produced and distributed. This software application is a tool that can be used by health care practitioners and clinic managers to estimate their vaccine coverage levels and help determine an appropriate course of action to improve coverage. ACASA is public domain software and can be installed at no cost to the health care practice.

CDC and the Association of Teachers of Preventive Medicine produced the "Increasing Adult Immunization Rates: What Works" interactive software (CD ROM) program targeted at private primary care providers who provide health care services primarily for adults. This program focuses on strategies to increase immunization coverage levels among adults and technical issues relating to adult vaccinations. Over 3,000 copies were distributed, free of charge, between October 2001 and January 2002.

NIP staff are developing guidance to be published in 2003 to help health care providers decide which combination of interventions from the "Vaccine-Preventable Disease" section of the *Guide to Community Preventive Services (Community Guide)*, is most appropriate for their practice settings and mix of patients. The *Community Guide* provides public health decision makers with recommendations to promote health and to prevent disease, injury, disability, and premature death, including a range of interventions that are known to raise adult vaccination coverage.

Recommendations
Revision of Standards for Adult Immunization Practices, which were first developed in 1990, were completed during 2001-2002. The updated standards were published in the *American Journal of Preventive Medicine* in 2003.

Development of an adult immunization schedule was begun in April 2001 by a sub-group of the Advisory Committee on Immunization Practices (ACIP) and published in 2002. The schedule provides a user-friendly summary of immunization recommendation for adults.

The Advisory Committee on Immunization Practices updated the recommendations for the use of influenza vaccine in the April 12, 2002 *MMWR*. This update included the recommendation that priority of early (October and November) vaccination be given to high risk groups, including adults 65 years and older.

In May 2002, NIP and the American Medical Association co-sponsored the second National Immunization Vaccine Summit. One hundred and thirty five representatives from over 50 public, private, and nonprofit organizations explored relevant issues and made

recommendations regarding the annual effort to encourage influenza immunization. By the close of the summit, 50 recommendations had been made in six categories – Communication; Vaccine Payment; Vaccine Handling, Distribution, and Storage; Community Immunization; State and Local Support and Promotion; and Implementation of Interventions.

Standing Orders

Dissemination of guidelines for health care providers is another important activity. CDC, in collaboration with the Advisory Committee on Immunization Practices and the Centers for Medicare & Medicaid Services (CMS), has recommended a key strategy called "standing orders" to improve influenza and pneumococcal vaccination levels in nursing homes throughout the country. A standing order enables nursing homes to provide these vaccinations to nursing home residents without an individual prescription.

In 2002, CDC and CMS completed a 3-year program to promote standing orders for Medicare patients in nursing homes. Initial data showed that standing orders are both more effective and more cost-effective than other available or used methods for immunizing nursing home residents and influenza and pneumococcal diseases.

Delivering Vaccines to Adults

Adult immunization coverage levels are well below the Healthy People 2010 goal of 90 percent, and racial and ethnic disparities in influenza and pneumococcal vaccine coverage rates continue to exist. In the 2001 National Health Interview Survey, 65% of whites, 52% of Hispanics, and 49% of Blacks reported receiving influenza vaccine in the preceding 12 months. The disparities for pneumococcal vaccination are even greater: 58% of whites, 33% of Hispanics, and 35% of blacks had received pneumococcal vaccination. HHS has made elimination of these disparities a priority, and to help address this priority, in 2002 CDC launched the Racial and Ethnic Adult Disparities in Immunization Initiative (READII) demonstration project.

The READII demonstration project is being conducted in five sites (Chicago, Illinois; Rochester, New York; San Antonio, Texas; Milwaukee, Wisconsin; and 19 counties in the Mississippi Delta region) to identify successful interventions to improve influenza and pneumococcal vaccination coverage among adults 65 years and older. The sites are collaborating with community partners to identify evidence-based interventions and innovative approaches to increasing immunization levels, such as supporting provider-based interventions, increasing community demand for vaccinations, enhancing access to vaccination services, and implementing vaccination interventions in non-medical settings. At the conclusion of the demonstration project, CDC plans to share lessons learned and should additional resources become available, replicate "what works" in other sites across the country.

Testing Vaccine Safety and Effectiveness

CDC is actively engaged in determining vaccine safety and effectiveness. CDC and three health plans assessed the effectiveness of influenza vaccine in patients age 65 or older in preventing hospitalizations and deaths during the 1996 through 2001 influenza seasons. Results showed that vaccination prevented 18-24% of the hospitalizations for pneumonia and 35-61% of all deaths. These findings support the concept that health plans should cover influenza vaccination, as well as actively promote the vaccine each fall.

In 2002, CDC collaborated with a health plan to examine whether influenza vaccine protects older adults against recurrent coronary events. This study examined 1,378 health plan enrollees who experience a first myocardial infraction in 1992-1996 to determine if receiving the influenza vaccine reduced the risk of recurrent coronary events. The results of this study suggest that influenza vaccine does not protect older adults against recurrent coronary events.

CDC and Emory University are planning to conduct a clinical trial to determine if protection from the pneumococcal polysaccharide vaccine (PPV) can be increased among elderly adults by using a combination of PPV and the pneumococcal conjugate vaccine (PCV). If a combination of vaccines if more effective than using PPV alone, studies will be performed to measure how much better this protects the elderly from pneumonia.

Understanding Gaps
CDC has commissioned two Institute of Medicine (IOM) studies related to vaccine financing. *Calling the Shots: Immunization Policies and Practices* found that "additional funds are needed to purchase vaccines for uninsured and underinsured adult populations within the states." Regional meetings were held in Chicago, Austin (Texas), and Los Angeles and a national meeting were held in Washington, D.C., to promote the study's conclusions and recommendations. Summaries of the Chicago and Austin meetings, which emphasized regional and local issues, have been published. Meeting reports from the other meetings will be published in 2003. *Financing Vaccines in the 21st Century: Assuring Access and Availability*, which was released in the summer of 2003, suggests that a new set of financing strategies are necessary to assure access to recommended vaccines and to sustain the availability of vaccines in the future, including vaccines that are recommended for adults.

CDC conducts research to better understand and improve adult vaccine delivery, including:
*** Reviewing adult immunization activities in the state immunization programs, 1997-99, to determine best practices.**
*** Tested AFIX (Assessment, Feedback, Incentive, and eXchange) methods, very successful for childhood immunization, for physicians of Medicare beneficiaries in New Jersey.**
*** Surveying African American physicians to identify barriers to delivery of adult immunization, and will use the results to design and evaluate a provider-based**

intervention to improve vaccination services.

*** Designing and evaluating a multi-component intervention in New Jersey to improve the use of influenza and pneumococcal vaccination and cancer screening (mammography and Pap testing) among African American women enrolled in Medicare.**

Influenza Communication and Communications Research

Beginning in August 2001, NIP introduced the Flu Bulletin, which is produced and distributed to provide the latest information on developments in vaccine production, supply, distribution and other relevant news. The publication is electronically distributed to partner organizations and is also available on the NIP website.

In 2002, NIP held a series of focus group discussions with Hispanic and African American seniors and in-depth interviews with physicians. The information is being used to assist the five Racial and Ethnic Disparities in Adult Immunization Initiative (READII) demonstration sites develop programs, educational materials, and media campaigns promoting influenza and pneumococcal vaccination to Hispanic and African American adults 65 years and older. This research found that regardless of race, gender, or geographic location, the most common reason for not getting an influenza vaccination was the belief that the vaccine could give them influenza. Participants were motivated by the concept of "protecting other," and the groups were most responsive to posters showing images of seniors with their families. When asked about pneumococcal vaccination, many people said they were not aware of it or that it was recommended for their age group.

NIP worked with a national social marketing firm to include questions related to immunization in the national Healthstyles Survey in 2002. One set of questions was designed to help CDC learn more about older Americans' knowledge and use of influenza and pneumococcal polysaccharide vaccines.

Adult Immunization Influenza Campaigns

As a result of the delay in the distribution of influenza vaccine during the 2001-2002 influenza season, NIP conducted a national public education campaign to help ensure that the first available doses of vaccine went to people at highest risk for complications from influenza, such as adults 65 years and older. NIP developed posters and fliers for health care providers to use with their patients. These materials stressed the benefits of influenza vaccination, especially for people at risk of serious complications, and were available in both Spanish and English. Over 30,000 posters and 10,000 kits containing materials and instruction on the most effective use of the materials were sent to local and state health departments, partners, professional health care organizations, and others. The materials were also available on the NIP website. In addition, a national media campaign targeting older adults, adults suffering chronic illness, and individuals at risk in African American and Spanish-speaking communities was conducted. Between September 2001 and January 2002, radio and television public service announcements and video news releases (VNRs)

were produced in Spanish and English and distributed nationally. Almost 8 million people in the U.S. saw the VNRs, and of these, approximately 1.5 million saw the Spanish-language VNRs. Over 5.5 million people viewed the television PSAs of which almost 4 million were Spanish-speaking, 40 million people throughout the county heard the audio news releases of which almost 38 million were Spanish-speaking, and over 19 million people heard the radio PSAs of which almost one million were Spanish-speaking.

During the 2002-2003 influenza season, the major vaccine manufacturers were able to produce a record supply of vaccine – 95 million doses. Eighty-two million doses were delivered by the end of October 2002. The ample supply of vaccine allowed NIP to concentrate on promoting the benefits of influenza vaccine for children and adults and the most current Advisory Committee on Immunization Practices influenza vaccine recommendations. NIP developed a number of print materials in English and Spanish, which were made available in multiple formats on the NIP web site. In mid-October, print materials were sent to 3,000 local and state health departments and private providers. Eight new posters and five new flyers were available for patient education as well as a checklist for organizations holding mass immunization clinics. In mid-November, a second set of print materials were distributed to 3,000 local and state health departments and private providers and 3,000 pharmacists in states where pharmacists can administer the influenza vaccine. These materials encouraged those who had not yet received the vaccine to get a shot to protect themselves and their loved ones. In addition, a national media campaign was launched in October 2002 to inform the public that an ample supply of influenza vaccine was available and to reinforce CDC's influenza immunization recommendations. In October, a press conference and a media teleconference were held, followed by a second media teleconference in November. Between October 2002 and January 2003, three English and two Spanish VNRs and four English and three Spanish audio news releases were produced and distributed to every major city in the country.

NATIONAL CENTER FOR HEALTH STATISTICS

CDC's National Center for Health Statistics (NCHS) is the Federal Government's principal health statistics agency. The NCHS data systems address the full spectrum of concerns in the health field from birth to death, including overall health status, morbidity and disability, risk factors, and health care utilization.

The Center maintains over a dozen surveys and vital statistics data files that collect health information through personal interviews, physical examination and laboratory testing, administrative records, and other means. These data systems and the analyses that result are designed to provide information useful to a variety of policy makers and researchers. NCHS frequently responds to requests for special analyses of data that have already been collected and solicits broad input from the health community in the design and development of its surveys.

A broad range of data on the aging of the population and the resulting impact on health status and the use of health care are produced from these systems. For example, NCHS data have documented the continuing rise in life expectancy and trends in mortality that are essential to making population projections. Data are collected on the extent and nature of disability and impairment, limitations on functional ability, and the use of special aids. Surveys are designed to examine the use of hospitals, nursing homes, physicians' offices, home health care and hospice, and are being expanded to cover hospital emergency rooms and surgi-centers.

In addition to NCHS surveys of the overall population that produce information about the health of older Americans, a number of activities provide special emphasis on the aging. They are described below.

The Second Longitudinal Study of Aging
The Second Longitudinal Study of Aging (LSOA II) is a collaborative project of the National Center for Health Statistics and the National Institute on Aging. This prospective survey consists of a baseline interview, the Second Supplement on Aging (SOA II), and two follow-up interviews fielded at two-year intervals. The SOA II interviews were conducted with a nationally representative sample of 9,447 civilian noninstitutionalized Americans 70 years of age and over. It was fielded as part of the 1994 National Health Interview Survey and interviews were collected in-person between 1994 and 1996. The follow-up interviews were administered by phone, one in 1997-1998 and one in 1999-2000.

The LSOA II is designed primarily to measure changes in the health, functional status, living arrangements, and health services utilization of older Americans as they move into and through the oldest ages. In addition, the study provides a mechanism for monitoring the impact of proposed changes in Medicare and Medicaid and the accelerating shift towards managed care on the health status of the elderly and their patterns of health care consumption. Finally, the LSOA II replicates the first Longitudinal Study of Aging which was conducted ten years earlier between 1984 and 1990. To this end, questions concerning physical functioning and health status and their correlates which were part of the first LSOA are repeated in the LSOA II. These include questions on activities of daily living, instrumental activities of daily living, and work-related activities, as well as medical conditions and impairments, family structure and relationships, and social and community support. In addition to these repeated items, the LSOA II questionnaire has been expanded to include information on risk factors (including tobacco and alcohol use), additional detail on both informal and formal support services, and questions concerning the use of prescription medications.

Public-use data files for the LSOA II are available at http://www.cdc.gov/nchs/lsoa.htm. These files include all public-use data derived from interviews conducted with the LSOA II cohort during the baseline contact and at each of the two follow-up contacts. Data

obtained at the follow-up interviews from surviving sample persons, as well as data obtained for decedents, are included. Finally, codebooks for each of the data files, Statistical Analysis System (SAS®) program files, and all LSOA II questionnaires have been made available as well. These data, when used in conjunction with data from the first LSOA, enable researchers to: a) identify changes in functional status, health care needs, living arrangements, social support, and other important aspects of life across two cohorts with different life course perspectives; and b) examine trends and determinants of "healthy aging." Users of the LSOA and LSOA II data have typically consisted of researchers in the Federal government and university settings, policy planners, and agencies and organizations serving older persons.

Health, United States, 2001, Special Excerpt: Trend Tables on 65 and Older Population
In March 2002, the *Health, United States, 2001, Special Excerpt: Trend Tables on 65 and Older Population* was published. This special excerpt from *Health, United States, 2001* contains select tables that include data on the 65 and older population.

Data Warehouse on Trends in Health and Aging
This data dissemination project, funded in part by the National Institute on Aging, is located in the Office of Analysis, Epidemiology, and Health Promotion. The Warehouse presents data on the health and health care use of the elderly population in the United States, from data sources within CDC, and from other federal sources such as the Census Bureau and the Centers for Medicare and Medicaid Services. The data are presented in interactive tables using a user-friendly dissemination tool, Beyond 20/20 software. The data in the tables can be manipulated and presented in charts and maps. The data are intended for use by policy and program analysts, researchers and the general public. The tables cover such topics as hospital and nursing home use, functional status, life expectancy, health risk factors and health care spending. The data are typically broken down by age, gender, race and Hispanic origin and contain explanations of the data source, data limitations, and interview questions. The data are often age-adjusted and measures of variability such as standard errors are provided. New developments in the Warehouse include statistical utility which allows users to perform statistical tests on the difference between two estimates or two trend lines and a Spanish version of the Warehouse. The Warehouse can be accessed at: http://www.cdc.gov/nchs/agingact.htm.

The Federal Interagency Forum on Aging-Related Statistics
The Forum was initially established in 1986, with the goal of bringing together Federal agencies with a common interest in database development and statistical compilation on issues in aging. The Forum has played a key role in improving aging-related data by critically evaluating existing data resources and limitations, stimulating new database development, encouraging cooperation and data sharing among Federal agencies, and preparing collaborative statistical reports.

The Forum has spent the past year updating its successful chartbook *Older Americans 2000: Key Indicators of Well-Being*. The purpose of this chartbook is to provide readers

with a broad range of indicators that can be used to track those areas of health and well-being that are improving for the older population, as well as highlight those areas that require more attention and effort.

To assist the Forum in developing recommendations for health insurance coverage measures in its chartbook, the Forum co-sponsored a workshop (with the Agency for Healthcare Research and Quality) entitled "Health Insurance for the Elderly: Issues in Measurement." The workshop presented Forum members with descriptions of current and future issues in health insurance coverage for the elderly as well as provided them with expert advice on short- and long-term data needs and measurement issues facing the Federal statistical system.

In addition to these activities, the Forum's working group on data needs spent the past year developing a template to collect detailed information on how residential settings for people age 65 and over are identified, defined, and classified in Federally-sponsored surveys. This activity addresses one of the nine data needs identified in *Older Americans 2000: Key Indicators of Well-Being* --"Distinguishing between different types of long-term care facilities and the transitions that occur between them." Working in conjunction with several other interagency efforts, the working group plans to collect key data elements from Federally sponsored surveys to produce a compendium that provides detailed information on how the surveys include or exclude "institutions" from their sampling frames.

During the coming year, the Forum will continue to address the data needs that are identified in the Forum's chartbook, particularly in areas such as transitions into and between long-term care settings, and improving measures of income and wealth in surveys. The Forum will also continue working on the next edition of *Older Americans 2004: Key Indicators of Well-Being*, while concurrently updating the existing indicators on the Forum's Web site at: http://www.agingstats.gov.

NHANES I Epidemiologic Follow-Up Study
The first National Health and Nutrition Examination Survey (NHANES I) was conducted during the period 1971-75. The NHANES I Epidemiologic Follow-up Study (NHEFS) tracks and re-interviews the 14,407 participants who were 25-74 years of age when first examined in NHANES I. NHEFS was designed to investigate the relationships between clinical, nutritional, and behavioral factors assessed at baseline (NHANES I) and subsequent morbidity, mortality, and hospital utilization, as well as changes in risk factors, functional limitation, and institutionalization.

The NHEFS cohort includes the 14,407 persons 25–74 years of age who completed a medical examination at NHANES I. A series of four follow-up studies have been conducted to date. The first wave of data collection was conducted from 1982 through 1984 for all members of the NHEFS cohort. Interviews were conducted in person and included blood

pressure and weight measurements. Continued follow-ups of the NHEFS population were conducted by telephone in 1986 (limited to persons age 55 and over at baseline), 1987, and 1992.

Participant tracing and data collection rates in the NHEFS have been very high. Ninety-six percent of the study population has been successfully traced at some point through the 1992 follow-up. While persons examined in NHANES I were all under age 75 at baseline, by 1992 more than 4,000 of the NHEFS subjects had reached age 75, providing a valuable group for examining the aging process. All NHEFS Public use data tapes are available via the Internet, CD-Rom, and from the National Technical Information Service for all four waves of follow-up. NHEFS data tapes contain information on vital and tracing status, subject and proxy interviews, health care facility stays in hospitals and nursing homes, and mortality data from death certificates. All NHEFS Public Use Data can be linked to the NHANES I Public Use Data.

While no full-scale interview re-contacts are currently planned for this cohort, mortality data collection is scheduled to continue indefinitely. NCHS will continue collecting cause of death information for the NHEFS cohort by matching records to the National Death Index. NCHS will produce an updated mortality file through 1997, which will extend the follow-up period to 25 years.

NHANES

The current National Health and Nutrition Examination Survey began field operations in April of 1999 as a continuous survey with some content changes anticipated every two years. Although a wide range of the conditions assessed in NHANES are most common among the elderly, several components are particularly relevant to aging research:

- **Muscle Strength, Impairment, and Disability: From 1999-2002, all persons age 50+ had measurement of isokinetic muscle strength of knee extensors and flexors, and from 1999-2004 all persons age 60+ will have an assessment of ability and time to get up from an armless chair five times and time to perform a twenty foot walk at the usual speed. Both sets of measures provide important data on physical impairment and function in the elderly and can be correlated to other disability related self reported items and other objective measurements obtained in the survey.**

- **Lower Extremity Disease: For the first time, the survey includes an evaluation of lower extremity disease in persons age 40+, including Ankle-Brachial Pressure Index measurement and assessment of peripheral neuropathy. These data are especially important for assessing the complications of diabetes and the prevalence of peripheral vascular disease.**

- **Visual and Hearing Impairment: Vision (age 12+) and hearing (age 20+) are being assessed including assessment of visual acuity, near vision (age 50+), pure tone audiometry thresholds, and typanometry. Sensory impairment is an important component of functional impairment in the elderly.**

- **Bone Mineral Status: Bone mineral status is being assessed including total bone mineral content and bone mineral density by dual X-ray absorptiometry. Osteoporosis is an important risk factor for hip fractures in the elderly.**

- **Cognitive Function: Cognitive function was assessed in persons age 60+ with the Digit Symbol Substitution Test from 1999-2002.**

- **Balance and Vestibular Function: The standard Romberg test of postural sway is being assessed in all persons age 20+. Balance impairment is related to the incidence of many fractures caused by falling, especially hip fractures in the elderly.**

- **Physical Activity: Beginning in 2003, all persons age 6+ are being asked to wear physical activity monitors to assess physical activity levels. The monitors capture locomotion-type activities such as walking or jogging and other movement that is difficult for participants to self-report. Physical inactivity is a risk factor for many diseases including coronary heart disease, colon cancer, and Type 2 diabetes.**

Vital Statistics on Aging

Information on mortality from the national vital statistics system plays an important role in describing and monitoring the health of both the institutionalized and non-institutionalized elderly population. The data include measures of life expectancy, causes of death, and age-specific death rate trends. The basis of the data is information from death certificates, completed by physicians, medical examiners, coroners, and funeral directors, used in combination with population information from the U.S. Bureau of the Census.

Effective with mortality data for 1997, additional detail on the aging population was included in the official national life tables. For the first time life expectancy and other life table values for the population aged 85 to 100 years were shown in the annual life tables by incorporating information from the Medicare program on the mortality experience of the aged population with standard information from the vital statistics system.

Effective with mortality data for 1999, two important changes are being implemented for state and national mortality statistics: (1) causes of death are coded and classified by the Tenth Revision of the International Classification of Diseases (ICD-10), replacing ICD-9, which was used by the U.S. during 1979-1998; and (2) the standard population used for age-adjusting death rates is changed from 1940 to the year 2000 population. The 1940 standard has been used for about 50 years. Use of ICD-10 affects the comparability of cause-of-death trends over time; the extent of the discontinuities is measured using a Comparability Study, results of which will be available at the time the 1999 mortality data are published in early 2001. The new population standard for age-adjusting death rates affects the absolute level of death rates for many causes of death, in particular, deaths from chronic diseases; it also affects the relationship of mortality among the race groups. Surveys currently examine the use of hospital inpatient and outpatient services (including emergency care), nursing homes, physicians' offices, home health care and hospice agencies.

With the publication of 2001 mortality rates, all rates for the years 1991-2000 were revised using populations consistent with the April 1, 2000 census. Populations for rates were produced for NCHS under a collaborative arrangement with the U.S. Census Bureau. The 2000 census allowed respondents to report more than one race for themselves and their household members and also separated the category for Asian or Pacific Islander into two groups (Asian and Native Hawaiian or other Pacific Islander). These changes reflected the Office of Management and Budget's (OMB) 1997 revisions to the standards for the classification of Federal data on race and ethnicity. However only one race is currently

reported on death certificate data in most states. Therefore, the 2000 census populations were "bridged" to the single race categories specified in OMB's 1977 guidelines for race and ethnic statistics in Federal reporting, that are still in use in the collection of vital statistics data. The 2000 census populations as well as the intercensal populations for 1991-1999 and postcensal populations for 2001 are employing the "bridged" race categories. As states gradually begin to collect data on race according to the 1997 OMB guidelines, it is expected that use of the "bridged" populations can be discontinued.

The National Health Care Survey

The National Health Care Survey (NHCS) is an integrated family of surveys conducted by the NCHS to provide annual national data describing the Nation's use of health care services in ambulatory, hospital and long-term care settings. Currently, the NHCS includes six national probability sample surveys and one inventory. These seven data collection activities include:

- The National Hospital Discharge Survey (NHDS) which examines discharges from non-Federal, short-stay and general hospitals;
- The National Survey of Ambulatory Surgery (NSAS) which examines visits to hospital-based and freestanding ambulatory surgery centers;
- The National Ambulatory Medical Care Survey (NAMCS) which examines office visits to non-Federal, office-based physicians;
- The National Hospital Ambulatory Medical Care Survey (NHAMCS) which examines visits to emergency and outpatient departments of non-Federal, short-stay and general hospitals;
- The National Health Provider Inventory (NHPI) which is a national listing of nursing homes, hospices, home health agencies and licensed residential care facilities;
- The National Home and Hospice Care Survey (NHHCS) which examines current patients and discharges from agencies that provide home health and hospice services; and
- The National Nursing Home Survey (NNHS) which examines current residents and discharges from certified and non-certified nursing homes that are licensed by the State, including freestanding facilities or distinct units that are part of a larger facility.

This family of provider-based surveys routinely redesigns survey content and other survey design features to meet the current and future needs for health care utilization information by researchers and policy makers in the areas of health services research, professional

medical services, epidemiology, and Federal agencies. While the surveys collect data on medical encounters for all age groups, secondary analysis of the public use microdata files can be performed on older age groups. The standard content of the surveys includes information on patient age, sex, race, expected source of payment, diagnoses, medical and surgical procedures, and disposition; but each survey also collects information pertinent to the particular health care setting. The National Nursing Home Survey, scheduled to be fielded in 2004, has been redesigned to collect data using a computer-assisted data entry system that will improve the quality of data collection and processing. The redesigned NNHS will collect new information on medication use, hospitalizations, and emergency room visits. A new item was added to the 2001 NHAMCS to collect information for emergency room encounters about whether the patient resides in a nursing home or other institution thus yielding important information about emergency care provided to both nursing home and community dwelling seniors. Data on drug prescribing at ambulatory care encounters has been used widely for examining inappropriate drugs prescribed to older patients. A pilot test is currently being fielded to collect data on medications administered to hospital inpatients on the NHDS. These surveys have been fielded from 10-40 years depending on the survey so trend data for aging can be analyzed for a variety of health care topics.

National Center for Chronic Disease Prevention and Health Promotion

Arthritis

Arthritis and other musculoskeletal diseases are among America's most prevalent and disabling chronic diseases; in 2001, 49 million adults reported doctor-diagnosed arthritis--nearly 1 of every 4 adults--making it among the most common health problems in the United States. An additional 21 million Americans reported chronic joint symptoms. Nearly 60 percent of persons 65 years and older have arthritis or chronic joint symptoms and their numbers are projected to increase from 21 million today to more than 41 million in 2030. Data are needed to describe the natural history of disease as well as to direct development of effective intervention efforts. To address the burden of arthritis, NCCDPHP:

- **implemented activities recommended in the National Arthritis Action Plan—A Public Health Strategy. This 1999 plan, now widely disseminated, was developed under the leadership of CDC, the Arthritis Foundation, and the Association of State and Territorial Health Officials. The plan proposes action in three major areas: surveillance, epidemiology, and prevention research; communication and education; and programs, policies, and systems. It is designed to encourage public health organizations, arthritis organizations, and other interested organizations to work together at the national, state, and local levels. Indeed, 36 states now have Arthritis Programs working to improve the quality of life among persons affected by arthritis.**

- evaluated physical activity and self management education programs. CDC analyzed the Arthritis Self-Help Course, showing the course to be a cost-saving intervention from both the societal and health care system perspectives. CDC is working with the Arthritis Foundation and several universities to analyze People with Arthritis Can Exercise (PACE®), a physical activity program designed specifically for people with arthritis.
- determined that blacks had an even higher prevalence of hip and knee osteoarthritis among whites and blacks than whites and their disease progressed faster than whites. The Johnston County, North Carolina Osteoarthritis Project follows 3200 white and black residents of a rural North Carolina county to determine the modifiable risk factors associated with the development and progression of hip and knee osteoarthritis--the leading causes of arthritis disability.

Alzheimer's Disease

Chronic neurological diseases, conditions common among elderly, causes high levels of morbidity, disability, family stress, and economic burden. For example, the costs due to dementias were estimated at $24 billion in 1985, and will increase as the population ages. However, the epidemiology of these conditions is poorly understood. NCCDPHP is studing the epidemiology of Alzheimer's Disease to determine disease rates, risk factors, and prevention factors.

Health Care and Long-Term Care Needs:
CDC provides information on critical health issues for older Americans through the Behavioral Risk Factor Surveillance System (BRFSS.) BRFSS is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors. States use BRFSS data to identify emerging health problems, establish and track health objectives, and develop and evaluate public health policies and programs. BRFSS tracks issues specific to the health of older Americans such as: colorectal cancer, mammography and pap exams, adult immunization, and health-related quality of life. BRFSS data on general health issues can also be analyzed for the older population, including such topics as obesity, physical activity, nutrition, diabetes, cardiovascular disease risk factors, smoking, seatbelt use, healthcare access, etc.

Heart Disease and Stroke
Growth in the elderly population is projected to be particularly rapid as the "baby boom" generation turns 65 years of age beginning in 2011. Untreated risk factors in this generation combined with aging will undoubtedly result in increased incidences of coronary artery disease, heart failure, and stroke. As the proportion of the elderly increases in the US population in the upcoming decades, greater health care resources and

expenditures will be required for the treatment and management of heart disease and stroke. Recognizing the current and potential immense burden of heart disease and stroke, in 1998 Congress funded CDC to launch a nationwide effort to help states develop the capacity, commitment, and resources necessary for a comprehensive program to prevent death and disability from heart disease and stroke and to improve the cardiovascular health of all Americans. The program expanded in 2001 and 2002. With fiscal year 2002 appropriations of $37 million for this program, CDC funded 29 states plus the District of Columbia (8 for basic implementation and 22 at a lower capacity-building level.)

Other highlights of CDC's efforts to address heart disease and stroke during 2001-2002 include:

With support from Congress, established the Paul Coverdell National Acute Stroke Registry, which measures and improves the delivery of acute care to stroke patients in order to reduce death and disability from stroke. Eight University-based prototypes tested methods from 2001-2002. CDC will begin to fund registries in state health departments in 2004. Data from the initial prototypes show that large gaps exist between recommended treatment guidelines and what is actually being practiced in hospitals. Participating prototypes have implemented quality improvement interventions to address these acute care gaps.

Undertook development of a National Public Health Action Plan to Address Heart Disease and Stroke, which was released in early 2003. This document charts a course for CDC, collaborating public health agencies, and other partners to prevent heart disease and stroke over the next two decades and beyond.

Publication and release of Women and Heart Disease: an Atlas of Racial and Ethnic Disparities in Mortality (2000), Men and Heart Disease: an Atlas of Racial and Ethnic Disparities in Mortality (2001), and Atlas of Stroke Mortality: Racial, Ethnic, and Geographic Disparities in the United States (2003).

Publication of Medicare claims data in Morbidity and Mortality Weekly Reports about hospitalizations for stroke (2003) and arterial fibrillation (2003)--major health problems for adults aged 65 years and older.

Diabetes

The burden of diabetes is heavier among elderly Americans. More than 18% of adults over age 65 have diabetes. And, because women make up a greater proportion of the population and women with diabetes live longer than their male counterparts, elderly women with diabetes outnumber elderly men with diabetes. Diabetes is one of the leading causes of death among women 65 and older. Elderly women with diabetes are particularly high risk for coronary heart disease, visual problems, hyperglycemia or hypoglycemia, and depression."

CDC funds diabetes "prevention" and control programs (DPCP) in all 50 states, the District of Columbia, and eight U.S. affiliated island jurisdictions to effect changes and

improvements in systems that care for and support people with diabetes. The primary goal of the DPCPs is to improve access to affordable, high-quality diabetes care and services. Priority is on reaching high-risk and disproportionately burdened populations which include the aged. CDC provides resources and technical assistance to state-based diabetes control programs to:

- **determine the size and nature of diabetes-related problems and why they exist,**
- **develop and evaluate new strategies for diabetes prevention,**
- **establish partnerships to prevent diabetes problems,**
- **increase awareness of diabetes prevention and control opportunities among the public, the health care and business communities, and people with diabetes, and**
- **improve access to quality diabetes care to prevent, detect, and treat diabetes complications.**

To address the unique and profound burden diabetes has on elderly women, CDC spearheaded the National Public Health Initiative on Diabetes and Women's Health. CDC and the initiative's co-sponsors, the American Diabetes Association, the American Public Health Association, and the Association for State and Territorial Health Officers, issued a call for action involving various organizations concerned about women's health. The co-sponsors and these organizations will directly support the implementation of specific strategies to help improve the health and well-being of women with or at risk for diabetes.

Oral Health

Over the past several decades the percentage of older adults who have their natural teeth has increased steadily, and complete tooth loss is no longer an inevitable consequence of aging. In fact, findings of a recent CDC analysis, submitted to MMWR's Public Health and Aging series, indicated that in more than half of the states the majority of older adults reported having most of their natural teeth (reporting loss of 5 or fewer teeth). This trend of increasing retention of natural teeth is expected to continue and result in improved oral function and quality of life. With increased tooth retention, however, older adults remain at risk for the two most prevalent oral diseases, tooth decay and periodontal disease (i.e. disease that destroys tooth-supporting tissues and can cause teeth to loosen and fall out). About 1 in 3 older adults has untreated tooth decay and 1 in 4 has serious periodontal disease. In the absence of timely prevention and control interventions these conditions can demand extensive and costly treatment. In the United States, older adults primarily pay for dental services out of pocket. Medicare does not cover routine services, and Medicaid provides limited coverage in some states

CDC is supporting a range of community-based approaches to reduce the burden of oral disease among older adults and assist increasing numbers of older adults better manage their oral health needs. CDC is working with its partners, especially with organizations focused on aging issues, to increase awareness of common oral conditions, risk factors, and healthy behaviors, particularly use of fluorides. Community water fluoridation remains the most effective and cost-effective method for prevention of tooth decay and brushing teeth twice daily with fluoride toothpaste is currently recommended for all persons. With its

partners, CDC is promoting cessation of tobacco use, which accounts for up to half of all cases of periodontal diseases in the United States.

CDC is also working to:

- **Enhance surveillance of oral diseases by assembling, in partnership with the American Academy of Periodontology, an expert workgroup to recommend new measures for periodontal infections**
- **Support research at CDC's Prevention Research Centers to examine the effectiveness of innovative strategies to promote adult oral health and assure timely receipt of clinical services**
- **Support water fluoridation through surveillance, training, and quality assurance**
- **Influence oral health policy and practice by developing and distributing guidelines based on sound science, e.g., fluoride use, infection control**

Elimination of Health Disparities

Chronic diseases disproportionately affect racial and ethnic minority populations in the U.S. The leading causes of death and disability (such as cardiovascular disease) are dramatically higher among these populations. Rates of death from stroke are 60% higher among African Americans than among whites. The prevalence in diabetes is higher among every racial and ethnic minority compared to whites of similar age. Among persons 65 years of age or older with one or more physician visits in the past year, influenza and pneumococcal vaccination levels among African Americans and Hispanics are substantially lower than those of whites. Death rates due to cancers, such as prostate and breast, are often higher among minorities as well.

NCCDPHP administers the Racial and Ethnic Approaches to Community Health Program (REACH 2010), a major part of the President's Initiative on Race. The goal of this program is to eliminate disparities in health status experienced by racial minority and ethnic populations in key health areas (including cardiovascular disease, diabetes, and immunizations) by the year 2010. REACH demonstration projects are two-phase projects through which communities mobilize and organize their resources in support of effective and sustainable programs that will eliminate the health disparities of racial and ethnic minorities. These demonstrations require collaboration of both program and research experts for the purpose of identifying and/or developing successful community-based disease prevention and health promotion models that can be replicated for the ultimate goal of eliminating health disparities among racial and ethnic minorities. In Phase I, REACH communities are granted 12 months to develop a Community Action Plan (CAP). Phase II communities are granted four additional years of funding to implement and evaluate the CAP. Thirty-two community coalitions were funded in FY 1999. The California Endowment contributed funding to support three additional organizations in the state of California identified through CDC's competitive process. In FY2000, 24 Phase II and 14 new Phase I communities were funded.

Through an inter-agency agreement, NCCDPHP provided $1 million to the Administration on Aging (AoA) to fund four demonstration projects focusing on health disparities among older racial and ethnic minority populations. In addition to the four projects funded directly by the AoA, other REACH 2010 communities include activities that impact aging populations as well. Elderly-specific projects were:

- **Boston Public Health Commission was funded to address cardiovascular disease (CVD), diabetes, and immunization in elderly African American communities.**
- **The Latino Education Project, Inc. was funded to address CVD and late-stage diabetes among rural and urban elders of Hispanic decent.**
- **Special Services for Groups, Inc. was funded to lead six community coalitions to address CVH, diabetes, and immunization disparities among individuals of Southeast Asian decent.**
- **National Indian Council on Aging, Inc. was funded to lead a community coalition focused on Indian and Alaska native elders in nine states.**

NCCDPHP funding will support Phase I of demonstration projects. These projects serve as the foundation for Phase II projects. The AoA is responsible for funding Phase II of REACH 2010 contingent upon availability of funds.

Cardiovascular disease (CVD) continues to be the leading cause of death in the United States for women. African-American women are at particular risk, with coronary heat disease (CHD) and mortality rates 35.3% higher and stroke rates 71.4% higher than for white women. Low socioeconomic status (SES) is also associated with higher CVD incidence and mortality. NCCDPHP is collaborating with the University of Alabama at Birmingham Prevention Research Center to produce the "Women's Wellness Sourcebook Module III Heart Disease and Stroke". The Sourcebook is a culturally-appropriate training curriculum designed to promote CVD prevention among low SES minority women by teaching Community Health Advisors (CHAs) to conduct risk-reduction counseling.

The Johns Hopkins University Prevention Research Center, in partnership with the NCCDPHP, is exploring how church-based programs in Baltimore can help prevent or control chronic diseases. Program components include weight control and nutrition, exercise and fitness, and smoking cessation, offered in the church by trained lay leaders; interwoven with the spiritual life and activities of the church, such as prayer groups, sermons, testimony, choir practice, and meals.

The St. Louis University Prevention Research Center, another NCCDPHP-supported center, has collected and analyzed determinants of physical activity among 3,000 US women aged 40 to 75 years, including 600 each from the following subgroups: African-American, Asian/Pacific Islander, American Indian/Alaska Native, Hispanic,White, and low education (high school or less).

Disability Prevention and Health Promotion

NCCDPHP is collaborating with the AARP, the American College of Sports Medicine, the American Geriatrics Society, the National Institute on Aging, and The Robert Wood Johnson Foundation to create a "National Plan to Increase Physical Activity Among Adults Aged 50 and Older." These partners hosted the "Blueprint Conference" on physical activity promotion in Washington, DC on October 30-31, 2000. **The "National Blueprint: Increasing Physical Activity Among Adults Aged 50 and Older" was published May 2001. (http://www.cdc.gov/nccdphp/dnpa/press/archive/blueprint.htm) The report represents a renewed and aggressive commitment to meet the challenges of enabling mid-life and older Americans to be more physically active. The same partners meet again on February 14, 2003 to discuss program and policy strategies to implement the recommendations outlined in the "National Blueprint" document.**

Tobacco

Of the 440,000 smoking-related deaths annually in the U.S., 87% are to persons aged 50 years or older and 67% are to persons aged 65 years or older. Lung cancer is the leading cause of cancer deaths among men and women 65 and over. At age 65, a smoker's life expectancy is 8 years shorter than a non-smoker's. In addition, more than 8 million Americans are currently living with one or more illnesses caused by their tobacco use. In 2000, persons aged 65 years or older had 4,250,000 physician office visits, 550,000 emergency room visits, and 475,000 hospitalizations for chronic obstructive pulmonary disease, a disease caused primarily by smoking. In 1997, smoking-related health care cost the Medicare program $20.5 billion. Despite a longer life expectancy, nonsmokers have 1.9 (women) to 2.9 (men) fewer years of living with disability.

There are health benefits to stopping smoking for men and women of all ages, so it's "never too late" to quit. If smokers quit at age 65, men gain 1.4 to 2 years of life and women gain 2.7 to 3.7 years of life. Several studies, including one specifically of Medicare recipients, found that older former smokers also have improved quality of physical and mental functioning compared with continuing smokers. Nearly 60% of smokers aged 65 years or older want to quit smoking, and about one third make a serious quit attempt (quit for a least one day) each year; older smokers are more likely than younger smokers to be successful if they make a quit attempt. However, only 15% of current smokers aged 65 years or older used an FDA approved medication on their last quit attempt, and fewer than 1% of current smokers aged 65 years or older received counseling (individual or class) on their last quit attempt.

The Centers for Disease Control and Prevention regularly publishes surveillance data on smoking among men and women aged 65 years or older. A recent MMWR reported that smoking prevalence among persons aged 65 years of older was 10.6%.

The Office on Smoking and Health collaborated in the development of two guidelines on cessation, the PHS Clinical Practice Guideline and the Community Preventive Services Task Force guideline. Effective interventions include: 1) individual, group, or telephone

counseling services, 2) 6 FDA-approved medications, 3) raising the price of tobacco products, 4) reducing the out-of-pocket costs of treatment, 5) sustained media campaigns promoting cessation, and 6) health care system strategies such as reminder systems to routinely identify tobacco users and promote the provision of treatment.

The Office on Smoking and Health (OSH) provided technical assistance to CMS on their demonstration project to provide cessation treatment under Medicare. In October 2002, the Center for Medicaid and Medicare Services launched the Medicare Stop Smoking Program (MSSP), a seven state research demonstration project to examine the most effective and cost effective ways to help Medicare beneficiaries, 65 and older, quit smoking. OSH supported this effort in 2003 by sending out a mailing to Medicare physicians in the 7 demonstrations states urging them to refer their senior patients who smoke to the services.

The Office on Smoking and Health will include age appropriate materials for older adults to address topics such as cessation and health consequences of tobacco use in the rollout of the upcoming Surgeon General's report titled, *The Health Consequences of Tobacco Use: A report of the Surgeon General, 2004.*

The Office on Smoking and Health and AARP are working together to disseminate age-appropriate tobacco prevention and control messages through a variety of communication channels.

The Office on Smoking and Health provides web-based educational materials for people who want to quit smoking and for clinicians who want to help them. For example, a collaborative CDC/NCI website www.smokefree.gov provides cessation information. Other materials available from CDC include:
You can Quit Smoking
http://www.cdc.gov/tobacco/quit/canquit.htm

Pathways to Freedom
http://www.cdc.gov/tobacco/quit/pathways.htm

Don't let another year go up in smoke: Quit Tips
http://www.cdc.gov/tobacco/quit/quittip.htm

Treating tobacco use and dependence: A clinical practice guideline
http://www.cdc.gov/tobacco/quit/guidline.htm

<u>Select healthcare and aging studies branch funding activities:</u>

***Prevention Research Centers Healthy Aging Research Network (HAN)*:**

The HAN is the only existing network of academic centers that focuses on community-

based research on older adult health and has special expertise in assessing interventions that target health disparities. The mission of the HAN, a consortium of seven Prevention Research Centers, is to better understand the determinants of healthy aging in older adult populations; to identify interventions that promote healthy aging; and to assist in the translation of such research into sustainable community-based programs throughout the nation. Currently the network has launched two national demonstration projects around physical activity. The HAN is collaborating on an in-depth, evidence-based review and statement of the role of public health in addressing physical activity for older adult populations. The network is also in the process of designing and implementing a HAN-wide survey of programmatic and environmental community-based physical activity resources for older adults across seven national sites and providing research expertise and capacity to the National Council on the Aging for their "best practices" cooperative agreement project.

Chronic Disease Directors' Healthy Aging Initiative:

CDD's Healthy Aging Initiative is a collaborative effort to develop the tools and expertise required for state and territorial health departments to address healthy aging more effectively. Key partners are the National Association of State Units on Aging (NASUA), the Centers for Disease Control and Prevention (CDC), and the Administration on Aging (AoA). In the past two years, CDD's Healthy Aging Initiative has focused on identifying the capacity of state health departments, facilitating partnerships between public health and aging networks at both the state and national levels, and articulating a vision for state public health action.

- **The Aging States Project: *The Aging States Project: Promoting Opportunities for Collaboration between the Public Health and Aging Services Networks* provides an overview of current state level health promotion and disease prevention activities for older adults and identifies barriers to success, program support needs, and the status of collaboration between state health departments and state units on aging across the United States and makes recommendations for improved collaboration, program delivery, and capacity development. The report is available at http://chronicdisease.org/aging_states_project.pdf.**

- **State Health Department Capacity: Building on the results of the Aging States Project, CDD is working with its partner organizations to define a role for state health departments in promoting healthy aging. Public health and aging experts representing state and federal agencies, non-governmental organizations, and academic institutions have participated in defining desirable characteristics of future state health department action in healthy aging, identifying a clear vision for this action and formulating plans to develop the necessary capacity to accomplish this vision.**

- **Healthy Aging Initiative Mini-Grant Program: In September 2002, CDD and NASUA funded ten state-based projects designed to improve the health of older Americans. Supported by CDC and AoA, these grants facilitated collaboration, in some cases for the first time, between state health departments and state units on aging, and drew on the respective strengths of the public health and aging networks in addressing the health needs of older adults. The projects, funded at approximately $10,000 each, included physical activity promotion, falls prevention, and the broader use of preventive health care services. Additional mini-grants will be awarded in 2003.**

National Programs to Support Healthy Aging:

CDC has funded five national organizations: the National Council on the Aging, the American Society on Aging, the Institute for the Future of Aging Services, the National Safety Council, and the American Association for Active Lifestyles and Fitness, to work individually and collaboratively to extend prevention opportunities to more older adults. Each of these organizations has a unique focus, and together their projects cover a wide spectrum of activities and topic areas in immunizations, physical activity, and injury prevention. In order to increase information sharing, encourage collaborative efforts, and improve technical assistance opportunities, CDC facilitated the creation of a formal network among the six organizations. Interaction and collaboration occur via a listserv, a professional development conference call series, and a yearly retreat.

Communications:

- **MMWR Special Series on Public Health and Aging. The following CDC program areas have taken this opportunity to highlight older adult health issues and identify the impact an aging population will have on their particular subject matter: arthritis, colorectal cancer screening, traumatic brain injury, immunization, physical activity, health-related quality of life, cardiovascular health, and oral health. The articles were widely publicized to the public health and aging networks through CDC's Healthy Aging Listserv, partners' newsletters, and conference presentations, in addition to the usual MMWR distribution lists.**

- **Public Health and Aging Listserv. The listserv provides a forum to connect public health and aging services professionals as well as a mechanism to inform the public about the health and social issues of older adults. Information distributed through the listserv includes funding opportunities; meetings and conferences; information and technological resources; training; discussion of priority areas for research and programs; best practices; publications, articles, and research findings in older adult health; and discussion of current issues, barriers, and successes in public health programs for older Americans.**

- **Healthy Aging for Older Adults Website. The website provides a single point of entry for CDC, external partners, and the public in accessing CDC information relating to aging and older adult health. The redesign effort included changing the color scheme, adding jpegs of vibrant older adults, additional content on disease and condition specific topics aimed at both professional and lay audiences, additional weblinks to other organizations with a role in older adult health, and descriptions of new CDC programmatic initiatives. The website address is www.cdc.gov/aging.**

The Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) is responsible for administering the Medicare program, Medicaid program, and the State Children's Health Insurance Program (SCHIP). CMS oversees insurance regulation, the survey and certification of health care facilities, and the Clinical Laboratory Improvements Amendments. We serve one in four seniors, children, people with end stage renal disease, and people with disabilities. We also provide beneficiaries with information about our programs, Medigap options, consumer research, and grievance and appeals processes.

CMS research helps to identify future trends that may influence our programs, meet the needs of vulnerable populations, and examine the cost effectiveness of our policies. Demonstration projects test, for example, how a new payment system, service delivery approach, preventive service or health promotion campaign actually affects our programs, beneficiaries, States, and providers. Evaluation projects provide information on the impacts of demonstrations and help us monitor the effectiveness of Medicare, Medicaid, and SCHIP.

Information follows on specific CMS research and demonstration projects related to the aged population:

01-114 Evaluation of Balanced Budget Amendment (BBA) Impacts on Medicare Delivery and Utilization of Inpatient and Outpatient Rehabilitation Therapy Services
Project Officer: Philip Cotterill
Period: September 2001–December 2004
Awardee: Health Economics Research
Funding: $998,540
Description: This project studies the impact of the Balanced Budget Act of 1997 (BBA) on the delivery and utilization of inpatient and outpatient rehabilitation therapy services to Medicare beneficiaries. Many of the BBA changes, some already implemented and others still under development, directly affect payment for rehabilitation therapy services. These policies include per beneficiary therapy limits applicable to certain outpatient settings, skilled nursing facility prospective payment system, home health agency prospective payment system, inpatient rehabilitation facility prospective payment system, long term care hospital prospective payment system, and outpatient therapy prospective payment system. This project will study the period 2000-2003, and will study changes in beneficiary access and utilization of therapy services across all these settings with special attention to changes in one or more settings that follow a payment change in another setting.
Status: This is a continuation and extension of previous work, "Medicare Post-Acute Care: Evaluation of BBA Payment Policies and Related Changes" (contract 500-96-0006/04), which covered the period 1996-1999.

02-079 Design and Implementation of a Targeted Beneficiary Survey on Access to Physician Services Among Medicare Beneficiaries
Project Officer: Renee Mentnech
Period: September 2002–September 2003
Awardee: Mathematica Policy Research, (DC)
Funding: $0
Description: The purpose of this project is to design and implement a targeted, short, beneficiary survey on access to physician services among Medicare beneficiaries. The intent of this targeted survey is to enhance the ability of CMS to determine, on as close to a real time basis as possible, whether Medicare beneficiaries are experiencing access problems in specific geographic areas.

01-144 Evaluation of Private Fee-for-Service Plans in the Medicare+Choice Program
Project Officer: Nancy Zhang
Period: September 2001–September 2004
Awardee: Abt Associates
Funding: $1,407,867
Description: The purpose of this project is to evaluate the new private fee-for-service (PFFS) option available under the Medicare+Choice (M+C) program. The evaluation will use a combination of primary and secondary data sources to evaluate the effects of the option on beneficiaries and program costs. Primary data will be collected through site visits to participating plans and beneficiary surveys. The PFFS plan option is one of the new types of organizations provided for under the M+C provisions. The project involves the Sterling Plan, which has been available to beneficiaries since July, 2000 and captures many beneficiaries who were previously enrolled in an M+C plan that withdrew from the program and for whom this plan is the only M+C option available. Analytic issues to be addressed in the evaluation can be grouped into three broad categories: 1) beneficiary analyses (enrollment, beneficiary experiences with the plan, utilization); 2) Medicare program impacts (payment); and 3) plan and provider impacts (market, program administration, participation).
Status: This newly initiated project is in the startup phase.

01-116 Evaluation of the Impact on Beneficiaries of the Medicare+Choice Lock-in Provision
Project Officer: Mary Kapp
Period: September 2001–September 2004
Awardee: Barents Group
Funding: $380,298
Description: This project will explore the impact on Medicare beneficiaries of the lock-in provision of the Balanced Budget Act of 1997 (BBA). The lock-in provision places limits on the frequency, timing and circumstances under which Medicare+Choice (M+C) enrollment elections can be made. These changes are phased in over a 2-year period beginning January 1, 2002. The purpose of this project is to: 1) examine the current (pre-lock-in) patterns of enrollment and disenrollment in M+C using existing CMS administrative data; 2) design a methodology to quantify the impact on Medicare beneficiaries of the lock-in provision; and 3) analyze the impact on beneficiaries of the first year of the lock-in provision.
Status: The project is in its developmental stage.

00-052 Evaluation of the Qualified Medicare Beneficiary (QMB) and the Specified Low-Income Medicare Beneficiary (SLMB) Programs
Project Officer: Noemi Rudolph
Period: September 1999–November 2002
Awardee: Health Economics Research
Funding: $1,466,933
Description: This project is designed to evaluate quantitatively and qualitatively the Qualified Medicare Beneficiary (QMB) and the Specified Low-Income Medicare Beneficiary (SLMB) Programs in the following areas: 1) the motivations and perceptions of enrollees and nonenrollees, 2) reasons for State variation in enrollment patterns, 3) the impact of enrollment on Medicare and Medicaid costs and service use, and 4) the impact of enrollment on out-of-pocket costs of eligible individuals. Primary data collection activities will include: a survey of a national sample of QMB and SLMB enrollees and of eligible non-enrollees, focus groups of enrollees and non-enrollees, a survey of State agencies, and case study interviews with officials from agencies and advocacy groups. Secondary data sources include: the Medicare Current Beneficiary Survey, the Medicare National Claims History file, the Medicaid Statistical Information System, Third Party Buy-In file, and the Medicare Enrollment Database. Descriptive and multivariate analyses will be conducted with the primary and secondary data.
Status: In September 2000, this project was modified to include case-study evaluations of State programs under the Building Partnerships for Innovative Outreach and Enrollment of Dual Eligibles grants. The period of performance for the evaluation project was also extended from September 2002 to December 2002 to cover the period of the grants. In early 2001, this project was modified to include a study on limitation on State payment for Medicare cost-sharing affecting access to services for Qualified Medicare Beneficiaries.

98-224 Home & Community-based Services Study
Project Officer: Susan Radke
Period: September 1998-March 2003
Awardee: Lewin Group
Funding: $2,308,371
Description: The purpose of this project is to design and implement a study of the impact of Medicaid home and community-based service (HCBS) programs on quality of life, quality of care, utilization, and cost. The scope of the study includes both Medicaid home and community-based service waiver programs as well as other Medicaid-funded long-term care services. The research project will study the Medicaid financing and delivery of services to older and younger people with disabilities in six States, and the Medicaid financing and delivery of services for individuals with mental retardation and developmental disabilities in six other States. One goal of the research is to assist Federal and State policy makers in gaining further knowledge about: 1) how Medicaid HCBS program funds are currently used; 2) how policies affect costs, access to care, and quality of services; and 3) key program design features that are helpful to schieving cost-effective use of program services.

Status: The 12 State site visits in phase one of the study are approved Phase two is currently in progress. The Office of Management and Budget (OMB) approved the Medicaid recipient survey, which was fielded late December 2001 to early January 2002.

01-210 Home Health Data Link
Project Officer: Ann Meadow
Period: September 2001–September 2002
Awardee: Fu Associates
Funding: $300,000
Description: This task is developing a working home health data management linking system with capabilities to link data from the Outcome and Assessment Information Set (OASIS) repository with patient level data from a variety of CMS data files. The Data Link will be made available to all CMS components and their contractors to meet individual data extract needs. This Data Link will create a multipurpose home health-linked file to supply the most frequently needed data extracts in a cost-efficient manner. The multipurpose home health-linked file will be comprised of the most utilized/requested/needed merged home health-related data. This file will include episode-level information from the national OASIS repository which has been linked with inpatient, outpatient, physician, and home health claims data; skilled nursing home data from the Minimal Data Set (MDS), and data from the Online Survey Certification and Reporting System/Quality Improvement Evaluation System (OSCAR/QIES).
Status: This newly initiated project is in the startup phase.

00-066 Design and Test of Evidence-Based Communications Strategies to Increase Consumer Awareness and Understanding of Long-Term Care Options
Project Officer: Ted Chiappelli
Period: September 2000–March 2003
Awardee: MEDSTAT Group (DC)
Funding: $7,095,615
Description: The object of this program will be to provide Medicare beneficiaries with information about their long-term care options, information on Medicaid long-term care policy, service delivery options and how to access information and assistance. This project will 1) document what is known about consumer understanding of long-term care issues in order to help beneficiaries with awareness of and how to provide useful and understandable information, 2) pilot test a variety of culturally competent, community-based communication and assessment activities related to long-term care planning and treatment options, 3) have ongoing evidence-based assessments of pilot activities, and 4) have ongoing reporting on the formative research and assessments.
Status: The contractor is preparing to launch the campaigns in the sites. They are at the halfway point, having completed all formative research including the environmental scans and testing. There will be four sites: Fresno, Delaware, West Palm Beach, and Milwaukee. Precampaign surveys to establish baseline information are underway in all four sites. The evidence-based communications activities will be conducted January-October 2002. This will be followed by post-campaign evaluation surveys and process measures. Analysis pursuant to delivery of evidence-based national strategy is due in March of 2003.

01-115 Assessment of Medicare & You Education Program
Project Officer: Lori Teichman
Period: September 2001–April 2004
Awardee: Barents Group
Funding: $1,777,640
Description: This project assesses how well CMS is communicating with Medicare beneficiaries, caregivers and partners. As part of the National Medicare Education Program (NMEP), CMS provides information to beneficiaries about the Medicare program and their Medicare+Choice options. The NMEP employs numerous communication vehicles to educate beneficiaries and help them make more informed decisions concerning: Medicare program benefits; health plan choices; supplemental health insurance; rights, responsibilities, and protections; and health behaviors. The goal of NMEP is to ensure that beneficiaries receive accurate, reliable information; have the ability to access information when they need it; understand the information needed to make informed choices; and perceive the NMEP (and the Federal government and its private sector partners) as trusted and credible sources of information.
Status: Work began in September 2001. The Medicare&You Regional Survey will be fielded in January 2002 through April 2002. The New Enrollee Survey is scheduled to start in late April 2002. The mystery shopping tasks (SHIPS and 1-800-MEDICARE) were pilot tested in December 2001. Site visits (data collection) for the partners' assessment, the needs/gaps assessment and the return on investment assessment is underway. Data is being processed on an ongoing basis for the audience feedback forms and the Medicare&You handbook postcards.

99-031 Telephone Customer Service Strategy–Customer Satisfaction
Project Officer: Lori Teichman
Period: May 1999–March 2002
Awardee: Lewin Group
Funding: $1,767,167
Description: This project provides assistance in developing and implementing a nationwide survey of customer satisfaction with telephone service provided by CMS' Medicare contractors. It will provide technical guidance and support in the development and implementation of a customer satisfaction methodology and put in place processes that will yield specific and standardized measures of customer satisfaction. The project focuses on the extent to which the caller is satisfied with the services provided, including the professionalism and courtesy of the customer services representatives, ease of use of the telephone system, and overall quality of service.
Status: A recommendation was developed on the feasibility of an independent beneficiary satisfaction survey for call centers. The survey was developed, piloted and implemented by telephone. Finally, a conference was developed and held on telephone customer service.

99-028 Expanded Evaluation of Medicare & You Handbook: 2000
Project Officer: Sherry Terrell
Period: March 1999–June 2002
Awardee: Research Triangle Institute, (NC)
Funding: $1,086,060
Description: The purpose of this project was to establish national measures of Medicare beneficiaries' knowledge of the basic Medicare program and their understanding of new Medicare+Choice options available under the Balanced Budget Act of 1997. The objectives of the project supported and provided feedback for monitoring and continuous quality improvement of National Medicare Education Program (NMEP) informational materials directed to the Medicare population. To achieve these objectives, the study evaluated the NMEP's Medicare&You Handbook: 2000 and selected information distribution channels such as the 1-800-MEDICARE toll free telephone line using a beneficiary program knowledge index. Additionally the effects of payments incentives to complete questionnaires and single mailing versus repeated mailings were tested.
Status: This project has been completed. The financial incentive payment experiment was found to have a significant effect on beneficiary response to the survey at each stage of data collection, ranging from 18.2 percentage to 8.3-percentage point differences. Repeated exposure to the handbook increased awareness. The multivariate analyses found the effect of receiving and reading the handbook on beneficiary program knowledge was modest but significant. Overall, beneficiaries who read the handbook demonstrated 12 percentage points higher knowledge scores about the Medicare program than those who did not receive the handbook or those who received but did not read it. The Medicare&You Handbook: 2000 has been successful in achieving multiple NMEP goals. The following reports are available from the National Technical Information Service, "Focus Group Results from the National Evaluation of Medicare and You 2000 Handbook: Beneficiaries (February 15, 2001)," Accession Number PB2001-103722, "Focus Group Results from the National Evaluation of Medicare and You 2000 Handbook: Non-Beneficiary Helpers (February 15, 2001)," Accession Number PB2001-103723.

96-080 HCFA On-Line: Market Research for Beneficiaries–I
Project Officer: Julie Franklin
Period: April 1996–December 2003
Awardee: Barents Group
Funding: $6,344,124
Description: CMS implemented a market research program to provide ongoing assessment of the information needs of our beneficiaries. It examined what information beneficiaries want and need and how such information can best be communicated to them. The Agency placed special emphasis on understanding the requirements of subgroups who may have special communication needs (e.g., vision-impaired or non-English-speaking beneficiaries). The project consisted of multiple phases, including conducting inventories of existing information on communication strategies relevant for beneficiaries, conducting focus groups to explore the information needs of beneficiaries, and collecting and analyzing survey data on information needs in beneficiary populations. This research will be used to help guide the development of CMS' communication strategy.
Status: A large series of focus groups have been conducted with the general population of Medicare beneficiaries including a number with special groups. An inventory of groups that work with beneficiaries is complete and includes information from approximately 170 organizations. Examples of

such groups are advocacy organizations, social service providers, health care providers, government agencies, and Medicare carrier and other insurance organizations. In addition, a special supplement to the Medicare Current Beneficiary Survey was used to collect information on the information needs and preferences of beneficiaries.

99-063 HCFA On-Line: Market Research for Beneficiaries–II
Project Officer: Julie Franklin
Period: September 1999–December 2003
Awardee: Barents Group
Funding: $14,367,373
Description: This project serves as a vehicle to conduct a variety of social marketing research with Medicare beneficiaries. The project is committed to carrying out targeted projects that document consumer reality through consumer research. Topics of the research are generally focused around communicating program benefits, appeal rights, health plan and provider choices, and treatment options to people with Medicare. Specific work has been done on existing Medicare publications, regulations, policies, developing message strategies and communication plans, monitoring desired behaviors, and evaluating the process.
Status: This is an extension of the work begun under 500-95-0057/02. This contract continues to conduct social marketing research on specifically identified initiatives that involve communication with Medicare beneficiaries.

06-173 Beneficiary Knowledge: Questionnaire Item Development and Cognitive Testing Using Item Response Theory
Project Officer: Sherry Terrell
Period: May 2001–May 2004
Awardee: Research Triangle Institute, (NC)
Funding: $268,853
Description: This project evaluates the effectiveness of the National Medicare Education Program (NMEP), CMS' primary information and education program. The evaluation focuses on the objectives of the NMEP: to 1) provide beneficiary access to information, 2) raise beneficiary awareness that information is available, 3) heighten awareness of some basic Medicare+Choice messages, and, 4) communicate information useful for making informed health services decisions. A substantial pool of Medicare beneficiary knowledge questions and tests cognitive reliability and validity of the items, assuring a consistent Medicare knowledge index over time. The content categories cover both core knowledge areas that generally remain consistent from year to year, as well as supplemental topics that may change more frequently. Medicare beneficiary knowledge data collected through the Medicare Current Beneficiary Survey (MCBS) will constitute the starting pool of questionnaire items. Item Response Theory (IRT) methodology is used to evaluate measures of knowledge and validate items in the MCBS knowledge index.
Status: This contract was modified to extend the period of performance through May 2004.

99-080 Implementation of Consumer Assessments of Health Plans Disenrollment Survey
Project Officer: Christine Smith-Ritter
Period: September 1999–November 2002
Awardee: University of Wisconsin - Madison
Funding: $4,458,022
Description: This project implements the Medicare managed care version of the Consumer Assessments of Health Plans (CAHPS) Disenrollment Survey. This is a survey of a sample of Medicare beneficiaries who have disenrolled from each Medicare+Choice contracting health plan eligible for inclusion in the study sample. CMS sponsored the development of a disenrollment version of the CAHPS survey (the Medicare CAHPS Disenrollment Survey), a Medicare fee-for-service version of CAHPS, and formats for reporting survey results that are easy for beneficiaries to understand in order to encourage beneficiary use of quality information. All three surveys include comparably worded questions on such topics as coordination of care, referrals to specialists, ease of obtaining needed care, patient/physician interaction, relations with office staff, customer service, and ease of obtaining specialty services and equipment.
Status: Multivariate analysis to group the reasons for reporting has been completed and additional subgroup and casemix analysis is underway. Annual health plan reports, interim 2001 reports, and consumer reporting of 2000 disenrollment rates and results have been mailed out or made public. The CAHPS effort is a 5-year cooperative agreement between the Federal agencies and three grantees, headed by the Agency for Healthcare Research and Quality.

97-265 Implementation of the Medicare Consumer Assessment of Health Plans Survey
Project Officer: Amy Heller
Period: September 1997–September 2002
Awardee: Barents Group
Funding: $25,592,481
Description: This project implements the Medicare version of the Consumer Assessments of Health Plans survey (CAHPS) in all Medicare risk and cost managed care plans. The primary purpose of the survey is to collect, analyze, and disseminate information to Medicare beneficiaries to help them choose among plans. It will also be used with other available data to monitor and evaluate the quality of care and relative performance of managed care plans, and to compare the satisfaction of beneficiaries in the managed care and fee-for-service systems. It is a nationwide satisfaction survey of Medicare beneficiaries, currently enrolled and recently disenrolled, from their managed care plans which proportionately samples a cross-section of Medicare managed care enrollees stratified by plan to assess their level of satisfaction with access, quality of care, plans' customer service, resolution of complaints, and their utilization experience.
Status: The survey completed it's 5th year of data collection at the end of December. The unadjusted response rate is 82 percent with 127,654 surveys returned by mail and 28,042 surveys completed by telephone. For the past three years, the survey has achieved a response rate greater than 80 percent. Since this is an ongoing effort, the survey was rebid in early spring of 2002.

00-043 National Implementation of Medicare Consumer Assessment of Health Plans Study - Fee-for-Service (CAHPS-FFS) Survey
Project Officer: Edward Sekscenski
Period: August 2000–August 2002
Awardee: University of Wisconsin - Madison
Funding: $7,378,706
Description: This project implements the Medicare Consumer Assessments of Health Plans Fee-For-Service (CAHPS-FFS) survey. Since 1998, CMS has collected information on consumer satisfaction and health services experiences of beneficiaries enrolled in managed care health plans through annual implementation of the CAHPS survey in those plans. Since 2000, CMS has surveyed a cross-section of Medicare FFS enrollees using a CAHPS questionnaire designed to assess their satisfaction and experiences with regards to health care access, quality of care, customer service, and services utilization. The primary purpose of both CAHPS surveys is to collect, analyze, and disseminate information to beneficiaries to help them in choosing between managed care health plans in the Medicare+Choice program and the Original FFS Medicare Plan program. Survey results also are used (together with clinical quality information and other available data) to monitor and evaluate the quality of care and relative performance of the Medicare program and assist in development of quality improvement initiatives for services delivered to Medicare beneficiaries.
Status: A contract modification to the CAHPS-FFS project, added in 2001, also permits development and testing of a CAHPS survey to be fielded among beneficiaries enrolled in private Medicare FFS health plans. Full implementation of this new component to the CAHPS-FFS Survey was added in Fall 2002 with reporting of information from this component to begin Fall 2003.

00-029 Development of Databases, Data Processing, Data Analysis and Table Construction for Skilled Nursing Facility Refinement Project
Project Officer: Carolyn Rimes
Period: May 2000–March 2002
Awardee: Jing Xing Technologies
Funding: $324,203
Description: This project uses files created for analysis to construct a file that presents the previous and newly created resource utilization groups for the purpose of analyzing the impact of the refined resource utilization groups on the skilled nursing facilities prospective payment system (SNF-PPS). SNF-PPS is a case-mix adjusted and wage-adjusted per diem payment system covering routine, ancillary, and capital costs. The development of the system was primarily based on administrative and staff time data, therefore one of these areas is ancillary care. CMS previously commissioned a study to explore possible refinements to the resource utilization groups. The study focused on the possible impact of ancillary care services on the resource utilization groups and detailed analysis of the more extensive care groups.
Status: The primary work is completed and is reflected in a paper prepared by Dr. Brian Fries, entitled "Analysis for SNF Refinement Project."

02-076 Evaluation of the Illinois State Pharmacy Assistance Program
Project Officer: William Clark
Period: September 2002–September 2005
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
Funding: $1,199,884
Description: This project will be an important first look at providing drug coverage to large numbers of Medicare beneficiaries. The goals of this project are to develop an understanding of the administration of a prescription drug benefit program and to developing an estimate of the cost effectiveness of providing prescription drug coverage to elderly beneficiaries. Specifically, it will conduct a descriptive evaluation, a cost-effectiveness analysis, and other analyses of specific aspects of the Illinois prescription drug demonstration.

00-110 Next Generation Medicare Managed Care Payment System
Project Officer: Benson Dutton
Period: September 2000–September 2002
Awardee: Urban Institute
Funding: $635,897
Description: This project assesses a possible "next generation" payment methodology (currently called the "Direct Model") for the Medicare+Choice (M+C) program. Under this direct model, managed care payments would move away (all or in part) from their current county FFS basis. In this direct payment approach, risk adjustment models could be calibrated using either a combination of FFS and managed care encounter data, or managed care data alone. This study
presents a conceptual paper that describes and makes possible one possible approach to managed care payments without a fee-for-service (FFS)-based county rate book.
Status: This project was completed.

99-036 Evaluation of New Jersey Hospital Association Demonstration of Performance Based Incentives
Project Officer: Edgar Peden
Period: September 2002–September 2004
Awardee: Health Economics Research
Funding: $498,104
Description: The purpose of this evaluation is to provide CMS with timely feedback on the implementation and operational experience of the demonstration site. A case study methodology will be used to develop both qualitative and quantitative information required to assess the strengths and weaknesses of the demonstration.
Status: Formerly called "Evaluation of the Competitive Pricing Demonstration–Phase I".

01-285 Medicare/DoD Subvention Demonstration - Validation of Payment Reconciliation
Project Officer: Ronald Deacon
Period: July 2002–June 2002
Awardee: PriceWaterhouse Coopers
Funding: $84,759
Description: This project validates payment reconciliation at the end of the third year of the demonstration and related consulting services as needed.

98-236 Department of Defense Subvention Demonstration Evaluation
Project Officer: Victor McVicker
Period: September 1998–March 2002
Awardee: RAND Corporation
Funding: $1,411,439
Description: Under the demonstration, enrollment in the Department of Defense's (DoD) Senior Prime plan is offered to military retirees over age 65 who live within 40 miles of the primary care facilities of one of the six sites, have recently used military health facility services, and are enrolled in Medicare Part B. The Senior Prime plans must meet all relevant requirements for Medicare+Choice plans. Medicare makes a capitation payment to DoD for each enrollee, and DoD must maintain a level of effort for health care services to all retirees who are also Medicare beneficiaries, whether or not they choose to enroll, that is based on fiscal year 1996 DoD experience. The evaluation seeks to answer the basic question: can DoD and Medicare implement a cost-effective alternative for delivering accessible and quality care to military-Medicare-eligible beneficiaries? The evaluation will seek the answer by examining issues in four basic areas: 1) enrollment demand; 2) enrollee benefits; 3) cost of the program; and 4) impacts on other DoD and Medicare beneficiaries.
Status: Reports are available from the National Technical Information Service (NTIS): accession numbers PB99 149056 and PB99 162505. In addition,
General Accounting Office (GAO) Reports are available on the GAO website (http:// www.gao.gov): GAO/HEHS 99-39 and GGD-99-161.

00-111 Survey of Medicare Beneficiaries Who Were Involuntarily Disenrolled from HMOs that Withdrew from Medicare or Reduced their Service Areas
Project Officer: Gerald Riley
Period: September 2000–October 2002
Awardee: University of Wisconsin - Madison
Funding: $551,823
Description: This project involved development and implementation of a survey that asks about the experience of beneficiaries whose plans withdrew from Medicare or reduced their service areas in January 2001. As a result, Medicare beneficiaries were disenrolled involuntarily, and had to enroll in another health maintenance organizations (HMOs) or go to fee-for-service (FFS). This project studies the impact of the HMO withdrawals on the beneficiary population. Beneficiaries are asked: what insurance arrangements they made after their plan withdrew from Medicare or reduced its service area; how their benefits and out of pocket costs were affected by new arrangements necessitated by their

plan's withdrawal; and whether they had to change doctors. The survey was conducted by mail with telephone follow-up and consists of 20-30 questions.
Status: The survey specifically addressed what type of new insurance arrangements beneficiaries made; what their informational needs were; disruptions to patterns of care; changes in benefits; changes in out of pocket costs; psychological impacts; and differences among subgroups of beneficiaries. Approximately 3,400 beneficiaries responded. Preliminary analyses indicated that most beneficiaries found the information they received about the withdrawals to be adequate, but there were clear information and understanding gaps among beneficiaries regarding the options available to them and the implications of plans withdrawing from Medicare.

97-022 ESRD Capitation Demonstration, Evaluation
Project Officer: Joel Greer
Period: August 1997–May 2002
Awardee: Lewin Group
Funding: $2,442,533
Description: The project uses survey, claims, and medical records data to evaluate the efficacy and cost-effectiveness of permitting Medicare beneficiaries with End Stage Renal Disease (ESRD) to enroll in managed care.
Status: Preliminary analyses are completed.

02-055 Investigation of Increasing Rates of Hospitalization for Ambulatory Care Sensitive Conditions among Medicare Beneficiaries
Project Officer: Mary Kapp
Period: September 2002–March 2004
Awardee: Research Triangle Institute, (DC)
Funding: $172,671
Description: The purpose of this project is to examine trends in the rates of inpatient hospital care of the elderly for ambulatory care sensitive conditions (ACSC) or "avoidable hospitalizations." This project uses existing Medicare data to examine the nature of the increases in ACSC hospitalizations, identify the sub-populations most affected, and explore more fully the reasons for these trends, with particular emphasis on policy issues which offer promise to reverse the trends. CMS data also provide sufficient sample size to permit investigation of supply factors, access issues, and geographic patterns.

01-168 Pilot Test and Analysis of the Medicare Health Survey for Program for All-Inclusive Care for the Elderly (PACE) and EverCare (MHSPE)
Project Officer: Ron Lambert
Period: September 2001–September 2004
Awardee: Health Economics Research
Funding: $428,922
Description: The purpose of this project is to determine the feasibility of implementing a variant of the Health Outcome Survey (HOS) for organizations that serve special populations, such as the Program of All-Inclusive Care for the Elderly (PACE) and EverCare. CMS developed a variant of the HOS for use with frail Medicare beneficiaries enrolled in specialty plans. This survey was intended to serve as a

means to compare outcome measures across Medicare+Choice and specialty plans and to support further research on payment to specialty plans. The primary goals of the Medicare Health Survey for PACE and EverCare (MHSPE) were: to improve response rates over the experience of the 1999 HOS and to more accurately describe the health and functional status of the target populations. CMS will pilot test the MHSPE on a subset of PACE and EverCare enrollees. This current project will: 1) administer the MHSPE to a sample of PACE and EverCare enrollees; 2) collect and validate MHSPE pilot survey data; and 3) perform the appropriate analysis to measure the impact on response rates of various approaches administered under the pilot survey.
Status: To assess the feasibility of applying HOS to specialty plans, the survey was administered to PACE and EverCare on a pilot basis in 1999. The response rates to the HOS for these plans were significantly below the response rates for the Medicare+Choice program.

96-056 Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance
Project Officer: Mary Wheeler
Period: September 1990–September 2002
Awardee: Center for Health Policy Research, University of Colorado
Funding: $3,203,917
Description: The purpose of this project is to develop a core data set that is the foundation for an outcome-based quality improvement (OBQI) system for the Program of All-Inclusive Care for the Elderly (PACE) program. The OBQI system consists of two phases during which the PACE sites complete the data instrument that contains items for outcome measurement and risk adjustment at specific time intervals. Using the data collected in the first phase, site-level reports can be produced summarizing the outcome measures. By comparing site-level case-mix adjusted outcome reports to other PACE site outcome reports, and to the site's previous outcome reports from earlier time periods, the site, CMS, and the State Medicaid agencies are able to identify areas that require further examination due to inferior (or perhaps superior) outcomes. In the second phase, the sites take a closer look at why and how the specific outcomes are achieved and makes recommendations for improve-ments in the case of poor (or perhaps superior) outcomes.
Status: Significant progress has been made in the development of outcome indicators for PACE. The OBQI contract was modified in October 1999, which expanded the period of performance and increased the level of effort to support the development of a Core Comprehensive Assessment (COCOA) instrument for PACE providers. Although this change in the timeline will delay the OBQI component, the burden of data collection on the PACE sites will be decreased.

01-214 Evaluation of the Program of All-inclusive Care for the Elderly (PACE) as a Permanent Program and of a For-Profit Demonstration
Project Officer: Frederick Thomas III
Period: September 2001–September 2003
Awardee: Mathematica Policy Research, (Princeton)
Funding: $819,772
Description: This is an evaluation of the Program for All-Inclusive Care for the Elderly (PACE) program. The evaluation studies PACE as a demonstration project, as a permanent program under Medicare, and as an option under Medicaid. This project first evaluates in terms of: site attributes,

patient characteristics, and utilization data statistically analyzed across sample sites and compared to the prior demonstration data. This project expands on the foundations laid in the previous evaluations of PACE by predicting costs beyond the first year of enrollment, assessing the impact of higher end of life costs and long term nursing home care, and assessing the impact of local treatment practices. Secondly, for the evaluation of the for-profit demonstration, the specific questions from the Balanced Budget Act should be answerable by comparing site attributes, patient characteristics, and utilization data of the permanent PACE providers to the for-profit demonstration providers.
Status: Phase I was extended to September 2003.

02-052 Integrated Payment Option Support Contract
Project Officer: Raymond Wedgeworth
Period: September 2002–September 2006
Awardee: Research Triangle Institute, (DC)
Funding: $496,279
Description: This demonstration utilizes the capabilities of integrated delivery systems by offering them a financial incentive to manage care and integrate services for beneficiaries across an entire defined episode of care. One example of an "episode of care" is inpatient treatment and post acute care for stroke where the patient would benefit from improved coordination of the range of services required for this diagnosis. A single episode payment would cover Part A (all benefits available to the covered population) and Part B (physician and possibly other services covered under Part B). This demonstration will compare alternate methods for calculating payment rates using different assumptions such as, co-morbid conditions, stage of diagnosis, and mix of services.
Status: CMS plans to implement the Integrated Payment Option demonstration in January 2004. CMS will select premier integrated delivery systems and give a bundled Part A & Part B payment (global payment) for all inpatient facility, post-acute and physician services related to 3-5 specific DRGs. Six to 8 sites will be selected. A second 12-month no-cost extension was approved extending the period of performance to June 2002.

84-007 Social Health Maintenance Organization Project for Long-Term Care: SCAN Health Plan
Project Officer: Thomas Theis
Period: August 1984–August 2003
Awardee: SCAN Health Plan, Kaiser Permanente Center for Health Research, Elder Plan Inc.
Funding: $0
Description: This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute- and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum

Status: A second 12-month no-cost extension was approved extending the period of performance to June 2002.

95-088 Second Generation Social Health Maintenance Organization Demonstration: Nevada
Project Officer: Thomas Theis
Period: November 1996–August 2003
Awardee: Health Plan of Nevada, Inc.
Funding: $0
Description: The purpose of this second-generation social health maintenance organization (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term-care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. The S/HMO-II model provides an opportunity to test models of care focusing on geriatrics. The Health Plan of Nevada is one of six organizations originally selected to participate in the project.
Status: The Balanced Budget Act of 1997 extended the demonstration period through December 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration. The Benefits Improvement and Protection Act of 2000 further extended the demonstration. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001, making the end date July 2003. Health Plan of Nevada (HPN) is the only operational site in
the demonstration. HPN began enrolling beneficiaries in the demonstration in November 1996. HPN enrollment at the end of 2001 was over 38,000 members.

97-210 Data Collection for Second Generation SHMO
Project Officer: Thomas Theis
Period: November 1996–December 2003
Awardee: Lewin Group
Funding: $7,052,998
Description: This project consolidated the data collection needs of the Second Generation Social Health Maintenance Organization (S/HMO-II) Demonstration. The project conducted initial and annual follow-up surveys for each beneficiary enrolled in the S/HMO-II demonstration. The information gathered served three primary functions: 1) baseline and follow-up data for the analyses; 2) clinical information to the participating S/HMO-II sites for care planning; and 3) data for risk-adjustment. In addition, this project supports a Congressionally mandated requirement for an evaluation component and formal Report.
Status: While multiple sites were originally planned for this demonstration, only one, the Health Plan of Nevada, actually implemented a SHMO II plan. The evaluation is designed to assess the impact of the SHMO II by comparing it with regular Medicare+Choice sites using measures of utilization, quality of care, and changes in participant health status over time. Reports to Congress were due November 2002.

97-018 Age Well Option (now referred to as TLC)
Project Officer: William Clark
Period: May 1997–April 2002
Awardee: Hebrew Rehabilitation Center for the Aged
Funding: $600,000
Description: In this project, community care and educational protocols are used to test the hypothesis that clients can be educated and empowered to more actively participate in their own health care planning, decisionmaking, and chronic disease management. The populations studied are individuals living in the Hebrew Rehabilitation Center for the Aged and those living in subsidized housing in the Boston community. Educational protocols are used to test the hypothesis that clients can be educated and empowered to more actively participate in their own health care planning, decision-making, and chronic disease management.
Status: In progress.

97-216 Evaluation of the Evercare Demonstration Program
Project Officer: John Robst
Period: September 1997–March 2002
Awardee: University of Minnesota, (Wash Ave)
Funding: $1,544,142
Description: For each of the five EverCare sites, two comparison groups were selected–1) nonparticipating residents in EverCare site nursing homes and 2) residents in nonparticipating nursing homes operating in EverCare demonstration cities.
Status: Site visits have been made to EverCare and non-EverCare facilities in each of the participating sites. A survey of Ever Care residents, proxies for residents, and control group nursing home residents has been conducted. Data are currently being analyzed. A final evaluation report was expected in late 2001.

00-085 Ambulatory Care Sensitive Conditions - II
Project Officer: Jennifer Harlow
Period: September 2000–March 2002
Awardee: Health Economics Research
Funding: $171,736
Description: The purpose of this task order is to further refine and validate hospital discharge rates for Ambulatory Care Sensitive Conditions (ACSCs) and develop a method for case-mix adjusting the ACSC rates at the Medicare+Choice (M+C) organization level. An ACSC is a hospitalization which was potentially avoidable with the provision of timely and effective ambulatory care. These tasks will be conducted using M+C inpatient encounter data submitted to CMS for the period July 1997 though June 1998 and also fee-for-service (FFS) claims data for the same time frame. The presence of an ACSC provides an indication that an individual may not have been receiving appropriate ambulatory care. The preliminary research using one year of M+C encounter data has shown that the rates can be applied at the M+CO level to evaluate the provision of care; however, before the ACSC rates can be used as a measure to evaluate M+CO performance, the rates should be further refined and validated for the population over age 65. Additionally, in order to compare rates of ACSCs at the M+CO level, a method

for case-mix adjusting rates needs to be developed in order to account for variation in the health status of M+CO enrollees.
Status: The contractor has conducted data analyses and has produced draft reports on the refinement of different ACSC indices and case-mix adjustment.

00-019 Risk Adjustment Implementation for Medicare Demonstrations
Project Officer: Victor McVicker
Period: September 1999–March 2002
Awardee: Fu Associates
Funding: $68,426
Description: This project provides technical assistance regarding risk adjustment to Medicare Choices Demonstration, Department of Defense Subvention Demonstration, Social Health Maintenance Organizations Demonstration I, and Social Health Maintenance Organizations Demonstration II populations.
Status: A modification to the contract provides an additional task for the contractor to calculate risk adjuster scores for the treatment and control groups used in the evaluation of the Community Nursing Organization demonstration.

02-060 Refinements to Medicare Diagnostic Cost Group (DCG) Risk Adjustment Models
Project Officer: Melvin Ingber
Period: September 2002–September 2004
Awardee: Boston University
Funding: $568,038
Description: A set of models to provide risk adjuster measures for the purpose of determining payments to capitated managed care organizations was developed under contract with CMS (#500-92-0020 Task Order 6), and were then further improved (#500-95-0048 Task Order 3). This task order will test the model for use in special populations to develop satisfactory payment for plans that enroll beneficiaries selectively based on their medical, functional or institutional condition. The DCG-based models are designed to use demographic and diagnostic information to project expenditures and to provide factors that could be used to multiply the ratebook amounts instead of the demographic factors currently used.

96-211 Refinements to Medicare Diagnostic Cost Group Risk Adjustment Models
Project Officer: Melvin Ingber
Period: September 1996–July 2002
Awardee: Health Economics Research
Funding: $845,277
Description: A set of models to provide risk adjuster measures for the purpose of determining payments to capitated managed care organizations has been developed and subsequently improved. This project further updates the models with newer data (1995-1996) and provides better adjustment for factors such as "working aged" and "institutionalized." These risk adjuster models go beyond demographic information in adjusting payments to include clinical information from medical claims, which is used to modify payment to reflect the expected expenditures for each enrollee. The diagnostic-cost-group (DCG) family of models is the most mature set of risk adjusters available and uses demographic,

diagnostic, and procedure information to project expenditures and provide adjusters that could be used to multiply the rate book amounts instead of the demographic factors.
Status: BBA required a hospital-based model be used by year 2000.

01-283 Testing Comprehensive Risk Adjustment Models for Coding Gameability
Project Officer: John Robst
Period: August 2001–April 2002
Awardee: Park Nicollet Institute
Funding: $215,116
Description: This will assist in assessing and evaluating five different risk adjustment models based on whether providers' discretion over coding may influence payment (gameability). Specifically, the project will convene a series of provider panels to address the gameability issue. In the assignment of codes from the International Classification of Diseases, Ninth version, Clinical Modification, providers have some legitimate discretion over the selection of the appropriate diagnosis that can be assigned to reflect the severity of the illness and to identify the presence of conditions. Within the range of defensible diagnoses, some codes generate higher payments than others, and providers could have an incentive to choose the code that gives the higher payment. To the extent that coding patterns shift from the one used as the basis for calibrating a risk adjustment model, such changes in coding would result in overpayments. The project will identify codes where there is room for discretion. It will then review the risk adjustment models to determine whether the logic of each model's grouping is more or less vulnerable to gaming through coding choices. The project's focus is not fraudulent assignment of diagnostic codes but on the legitimate possibilities available within normal clinical and coding practices.
Status: Diagnostic codes have been identified for consideration by the expert panels. A pilot evaluation of two conditions has been conducted. The contractor is recruiting expert panels for the remaining conditions.

02-059 Survey of Renal Dialysis Centers
Project Officer: Mary Stojak
Period: September 2002–February 2003
Awardee: University Renal Research and Education Association
Funding: $145,844
Description: The purpose of the task order is to measure the amount and quality of nutrition therapy that is currently being provided to beneficiaries receiving dialysis.

00-064 Evaluation of Community Nursing Organization (CNO) Demonstrations, Phase II
Project Officer: Victor McVicker
Period: September 2000–September 2002
Awardee: Abt Associates
Funding: $246,367
Description: This project evaluates the design and implementation of Phase II of The Community Nursing Organization (CNO) Demonstration. The Phase I evaluation covers the initial period of operation of the demonstration. The Phase II evaluation provides for longer term followup of early participants and also includes an assessment of the effects of the CNO intervention on later participants

whose data were not available for Phase I evaluation. The Phase II evaluation requires the use of hierarchical-coexisting-conditions risk adjusted estimates of Medicare expenditures for Medicare beneficiaries who participated in the demonstration, as well as for a new comparison group. The calculation of the risk adjuster scores is being contracted separately and the resulting data will be made available to this Phase II evaluation.

Status: The demonstration has been extended several times, most recently by section 532 of the Balanced Budget Refinement Act (BBRA) of 1999, which extended the demonstration through December 2001, and mandated an additional evaluation of the demonstration. Section 632 of the Benefits Improvement and Protection Act of 2000 replaced the mandated evaluation required by section 532 of BBRA with a preliminary report due to Congress by July 2001 and a final report to Congress by July 2002.

98-234 Decisionmaking in Managed Care Organizations
Project Officer: Brigid Goody
Period: July 1998–August 2002
Awardee: Health Economics Research
Funding: $257,749

Description: This task order examines a broad range of managed care decision-making strategies, their implications for the development and diffusion of new technologies and their impact on future health care costs, especially Medicare program costs. The project had three phases. First, case studies of managed-care organizations focused on components of plan decision-making related to the scope of insurance coverage: benefits offered, premium and coinsurance structure, and coverage of specific technologies. Second, it examined how the research and development decisions of private firms are affected by increased managed care penetration. Third, it developed a conceptual framework for simulating the long term growth in health care expenditures, especially Medicare program costs, which incorporates the interaction between increased managed care penetration and the research and development process.

Status: A final report presenting findings from the interviews with managed care organizations, contracting hospitals and research and development companies has been received. They found that, while managed care plans attempt to control use of certain technologies, their ability to do so is more restricted than expected. Similarly, managed care undoubtedly influences manufacturer research-and-development investment decisions through coverage and payment policies. It is, however, not clear that it has changed the likelihood that cost-increasing technologies will come to market, nor has it altered the fundamental feedback relationship among insurance, technological innovation, and health care expenditure growth.

00-123 Data Collection to Support Policy Analysis of Choices Offered to Medicare+Choice Enrollees and Choices Made by Enrollees
Project Officer: Carlos Zarabozo
Period: September 2000–July 2002
Awardee: Actuarial Research Corporation
Funding: $140,185
Description: This project collects data from Medicare+Choice (M+C) organizations regarding the benefits offered to enrollees of M+C plans and the choices that Medicare beneficiaries make as M+C enrollees. The project will collect information about: 1) The number of Medicare beneficiaries in each M+C organization whose M+C benefit package is supplemented or paid for by a (former) employer or union, and how the benefit offerings of employment-based Medicare retiree coverage compare to the benefit offerings of individual Medicare enrollees of the organization; and 2) The choices made by current and new enrollees when the M+C organization offers multiple benefit packages in a particular county.
Status: The survey was fielded in January of 2002, with results available June of 2002.

02-082 Refinement of Risk Adjustment for Special Populations
Project Officer: Ronald Lambert
Period: August 2002–July 2004
Awardee: Health Economics Research
Funding: $399,740.44
Description: This project will review and evaluate potential risk adjusters and develop a preliminary payment approach for frail populations. One of the purposes of this contract modification is to refine and further develop frailty adjustment. In 2000, CMS implemented a risk adjustment methodology that uses hospital inpatient diagnoses, and pays Medicare+Choice (M+C) organizations a blend of 10 percent of the risk adjustment amount and 90 percent of the previous demographic payment amount. The payment approaches under consideration involve the application of a frailty adjuster in conjunction with the inpatient and ambulatory model that will be used for M+C organizations in 2004.
Status: CMS is considering implementing frailty adjustment for demonstrations and PACE in 2004. Prior to implementation, CMS will be sharing information with the demonstrations, PACE, and other interested parties and pursuing clearance through the Office of Management and Budget (OMB) and the Department of Health and Human Services. Refinements and further development will be necessary to reflect more recent research or changes in policy direction. This is a modification to existing contract with Health Economics Research (HER, #500-99-0038).

02-064 Evaluation of Programs of Disease Management (Phase I and Phase II)
Project Officer: Lorraine Johnson
Period: September 2002–September 2007
Awardee: Mathematica Policy Research, (DC)
Funding: $1,908,308
Description: The objective of the evaluation is to assess the effectiveness of disease management programs for serious chronic medical conditions such as advanced stage diabetes and congestive heart failure (CHF). Although the participating demonstration sites may also vary by classification of disease

severity, the availability of a pharmacy benefit, population targeted, scope of patient care covered, type of comparison group and other factors, they will have in common the goal of improving quality and reducing cost of health care received by chronically ill Medicare beneficiaries through specific services targeted to the management of a particular medical condition. The evaluation will study the independent effects of both the disease management program and a drug benefit as well as any interaction between the two.
Status: RTOP issued to RADSTO Medicare May 16, 2002.

02-066 Payment Development, Implementation, and Monitoring Support for the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) Disease Management Demonstrations
Project Officer: J. Donald Sherwood
Period: September 2002–September 2007
Awardee: Actuarial Research Corporation
Funding: $453,557
Description: The purpose of this task is to support CMS in implementing a demonstration project in three or more sites to provide disease management services to Medicare beneficiaries with advanced stages of congestive heart failure, coronary heart disease, and/or diabetes. Specifically, this project 1) provides general technical support in the analysis of rate proposals and assistance in calculating the appropriate payment rates (both initial and annual updates) for the selected projects; 2) educates demonstration sites regarding payment calculations, billing processes and requirements, and budget neutrality requirements; 3) monitors payments and Medicare expenditures to assure budget neutrality, including designing data collection processes for use in collecting and warehousing necessary data elements from sites and CMS administrative records for assessing performance; and 4) performs financial analysis to assist in the financial settlement and reconciliation.

98-256 Medicare Clinical Laboratories Competitive Bidding Demonstration Planning and Technical Assistance
Project Officer: Michael Park
Period: September 1998–September 2002
Awardee: Research Triangle Institute, (DC)
Funding: $883,568
Description: The project evaluates Part B laboratory test charges in order to calculate a relative value scale. This is a first step toward the development of a process for refining the fee schedule. The development of a final relative value scale is beyond the scope of this study. The current project work is limited to analyzing current laboratory charge data to help inform potential policies.
Status: This project was initially intended to provide support in the implementation and operation of the clinical lab competitive bidding demonstration, and the development and evaluation of models for bidding of Part B services other than physician services, lab services, and durable medical equipment. The focus of the study is in response to the Institute of Medicine report entitled "Medicare Laboratory Payment Policy: Now and in the Future."

01-111 Environmental Scan for Selective Contracting Practices with Efficient (Qualified) Physicians and Physician Group Practices; Profiling Techniques; Incentive Payments and Barriers to Selective Contracting
Project Officer: Benson Dutton
Period: September 2001–March 2003
Awardee: Health Economics Research
Funding: $303,803
Description: This project undertakes an environmental scan of physician service payers/employers to identify (a) recent fee-for-service payer and managed care plan selective contracting arrangements with efficient/high quality physicians and physician-group practices; (b) best practice profiling methodology/criteria used in selective contracting including financial profiling; (c) barriers to selective contracting such as "any-willing-provider" or "freedom- of-choice" laws; and (d) bonus arrangements being paid to high quality physicians. Descriptive and qualitative analyses based on this environmental scan should lead to a recommendation of best practice profiling criteria that identify efficient and qualified physicians and group practices. Quantitative analyses estimate current Medicare (Part B) physician expenditures and simulate possible program savings (losses) from alternative selective contracting policies based on best industry practice found in the environmental scan. The use of physician profiling (quality and economic) by payers and employers in evaluating physicians for the purposes of staff appointment, reappointment, and/or selective contracting has been suggested as an accepted industry practice that would modernize Medicare payment practices. In addition, the use of bonus payments to efficient and high quality physicians to keep Medicare program costs down and quality of service up is cited as another industry practice appropriate for modernization of Medicare.
Status: The contractor presented work on research methods and examples of private sector physician efficiency profiling at the Diagnostic Cost Group conference in Boston.

96-081 Evaluation of Group-Specific Volume Performance Standards Demonstration
Project Officer: John Pilotte
Period: September 1996–September 2002
Awardee: Health Economics Research
Funding: $2,220,440
Description: The purpose of this task order is to comprehensively evaluate the Group-Specific Volume Performance Standards Demonstration. Additionally, there is a group of tasks to provide technical support for setting sites' targets and measuring their actual performance. The goal of the demonstration is to test the feasibility of this partial-risk-bearing payment arrangement between CMS and qualifying physician-based organizations in the fee-for-service (FFS) market, whereby FFS rules apply within the context of a performance target, beneficiaries are not enrolled, and physician-sponsored organizations develop structures and processes to manage the services and cost of care received by FFS patients.
Status: In developing the final design parameters of the GVPS demonstration, simulations were conducted to analyze low and high expenditure outliers, eligibility mix changes, components of growth rates by type of service, and effects of case-mix adjustments. These analyses reveal sources of variability in growth rates, and support development of options for setting targets and calculating updates and bonus payments. The evaluator is awaiting the initiation of the demonstration.

00-117 Evaluation of the Informatics, Telemedicine, and Education Demonstration
Project Officer: Carol Magee
Period: September 2000–July 2004
Awardee: Mathematica Policy Research, (Princeton); Urban Institute
Funding: $1,419,493
Description: The Balanced Budget Act of 1997 mandates a single, 4-year demonstration project using an eligible health care provider telemedicine network. The demonstration involves the application of high-capacity computing and advanced telemedicine networks to the task of improvement of primary care and prevention of health complications in Medicare beneficiaries with diabetes mellitus. This project evaluates the impact of using telemedicine and medical informatics on improving access of Medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of beneficiaries. The Informatics, Telemedicine, and Education Demonstration project uses specially modified home computers, or home telemedicine units (HTU) linked to a Clinical Information System (CIS), and studies beneficiaries residing in medically under-served rural or medically under-served inner-city areas. The HTUs in patients' homes allow video conferencing, access to health information, and access to medical data, in both Spanish and English. The demonstration project is being conducted as a randomized, controlled clinical trial. Impact of the telemedicine intervention on health outcomes will be evaluated by comparing health outcome measures of the intervention group to a control group.
Status: This evaluation began in November 2001. The evaluator and the demonstration consortium are arranging for the initial site visits and personnel interviews in order to accomplish the descriptive component of this evaluation. Over the last year, CMS and the Columbia Consortium have been negotiating the details surrounding data-sharing, site-access, and publication rights.

00-166 Informatics, Telemedicine, and Education Demonstration
Project Officer: Pat Brocato-Simons
Period: February 2000–February 2004
Awardee: Columbia University
Funding: $17,356,211
Description: The project focuses on Medicare beneficiaries with diabetes because of the high prevalence, cost, and complexity of this condition. It also focuses on beneficiaries living in Federally-designated medically-underserved areas in order to demonstrate that obstacles to bridging the "digital divide" in health care are not intrinsic to the targeted population. The project involves a consortium of health care delivery organizations in New York City (urban component) and upstate New York (rural component); industry partners who are providing hardware, software, technology, and communication services; and the American Diabetes Association, which is providing the educational website for the project. The consortium is led by Columbia University. Intervention participants receive a home telemedicine unit which facilitates uploading of clinical data, interaction with a nurse case manager, and patient education.
Status: The experience to date indicates that large scale home telemedicine as a strategy for disease management is technically feasible, can be done in a fashion that meets current requirements for health care data security, and is highly acceptable to those who agreed to participate in this study. No evidence

has been found to indicate that Medicare beneficiaries living in federally-designated, medically-underserved areas are unable or unwilling to use computers or the World Wide Web to obtain health care information and health care services.

95-023 Maximizing the Effective Use of Telemedicine: A Study of the Effects, Cost Effectiveness, and Utilization Patterns of Consultation via Telemedicine
Project Officer: Joel Greer
Period: September 1995–September 2002
Awardee: Center for Health Policy Research, University of Colorado
Funding: $2,198,968
Description: This project is evaluating the medical effectiveness, patient and provider acceptance, and costs associated with telemedicine services, as well as their impact on access to care in rural areas. The demonstration involves ten rural hospitals, one rural referral hospital, and one urban hospital. Planned services for the demonstration include interactive video consults for teleradiology, telepathology, and, where available, telesonography, electrocardiography, and fetal monitoring strips. Payment for related physician services is expected to be made under a waiver of Medicare payment regulations. The goal of the project is to evaluate whether specialty telemedicine services provided by hospital networks produce change with respect to medical effectiveness, patient and provider satisfaction, cost, and access. Hypotheses include telemedicine improving differential diagnoses and treatment, patients and providers being as satisfied with telemedicine as with on-site services, telemedicine services being less costly than on-site services, and telemedicine improving access to a wider range of health care services.
Status: A revised OMB approval was obtained, valid until June of 2001. Additional research projects are being considered. The demonstration to be evaluated encountered significant problems and this forced the evaluator to revise their approach.

00-113 Evaluation of Programs of Coordinated Care and Disease Management
Project Officer: Carol Magee
Period: September 2000–September 2005
Awardee: Mathematica Policy Research, (DC)
Funding: $3,018,839
Description: This project evaluates a group of Congressionally mandated demonstration programs and two Agency-initiated demonstration programs. The demonstrations test various methods of managing care in the fee-for-service (FFS) Medicare environment. Demonstration of the effectiveness of programs of care coordination or management are complicated, not only by wide variations in program staff, funding mechanisms, interventions and stated goals, but by the evaluator's definition(s) of effectiveness. CMS is investigating the potential of care coordination or case management to improve care quality and control costs in the Medicare FFS program. Under the Balanced Budget Act of 1997, a demonstration of approaches to coordinated care of chronic illnesses in up to nine separate sites is required. An evaluation of best practices in coordinated care and a study of demonstration design options was conducted.
A separate demonstration, the Medicare Case Management Demonstration, focuses on programs of case management specific to diabetes and congestive heart failure. This evaluation assesses the effectiveness of various strategies for coordinating care in the FFS Medicare environment, in a total of 11

demonstration sites. The participating demonstration sites vary by: corporate structure, types of medical conditions addressed, scope of patient care covered, beneficiary eligibility, and source of comparison data.
Status: The contractor is working with the demonstration sites to finalize randomization procedures and is completing the design of the patient and physician surveys in preparation for submitting an OMB approval package.

00-082 Implementation Support for the Medicare Coordinated Care Demonstration
Project Officer: Cynthia Mason
Period: September 2000–March 2005
Awardee: KPMG Consulting
Funding: $2,012,184
Description: This project provides CMS with technical monitoring and assistance in project implementation and operation of the Medicare Coordinated Care Demonstration. The demonstration tests models of coordinated care (case management and disease management) that seek to improve the quality of services provided to beneficiaries who have a chronic illness and manage expenditures of the Medicare program.
Status: This support contract is meeting with sites and conducting training sessions on billing and cost reporting.

99-068 Aging in Place: A New Model for Long-Term Care
Project Officer: Renee Mentnech
Period: June 1999–June 2003
Awardee: Curators of the University of Missouri, Office of Sponsored Program Administration, University of Missouri - Columbia, Sinclair School of Nursing
Funding: $2,000,000
Description: The goal of the "Aging in Place" model of care for frail elderly is to allow elders to remain in their homes as they age, rather than requiring frequent moves to allow for more intensive care if and when it becomes necessary. Although a planned element of the program is a new senior housing development, the program currently targets elderly residents of existing congregate housing.
Status: As a result of changes to the study plan, the applicant requested an increase in the first-year award with a corresponding reduction in the Years 2-4 awards and no change in the total budget. This change was approved.

COORDINATED CARE TO IMPROVE QUALITY OF CARE FOR CHRONICALLY ILL MEDICARE BENEFICIARIES
Description: This demonstration is testing whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among certain beneficiaries that constitute a small proportion of the Medicare fee-for-service (FFS) population, but account for a major proportion of Medicare expenditures. Fifteen sites were selected as a part of a pilot project to provide case management and disease management services to certain Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 (BBA) authorizes this demonstration to test existing

models of coordinated care interventions to improve the quality of services provided to certain chronically ill beneficiaries and manage expenditures to the Medicare program. The Act requires that the projects target chronically ill Medicare FFS beneficiaries that are eligible for both Medicare Parts A and B and requires that the projects' payment methodology be budget neutral.
Status: Implementation began in early 2002.

01-222 Implementation Support for the Medicare Participating Centers of Excellence Demonstration
Project Officer: Raymond Wedgeworth
Period: September 2001–March 2005
Awardee: Barents Group
Funding: $379,991
Description: The purpose of this project is to assist CMS in the implementation of the Quality Partnerships Demonstration project. Under this demonstration, CMS selects premier cardiovascular and orthopedic programs and gives a bundled Part A & Part B payment (global payment) for all inpatient facility and physician services related to specific DRGs. Implementation support includes: 1) calculating the appropriate payment rates (both initial and annual updates); 2) developing the Office of Management and Budget (OMB) waiver cost estimate; 3) educating demonstration sites regarding payment calculations, 4) planning and implementing a pre-demonstration implementation conference, and 5) providing general technical support to CMS in carrying out the demonstration.
Status: This newly initiated project is in the startup phase.

01-112 Quality Monitoring for the Medicare Participating Center of Excellence Demonstration
Project Officer: Jody Blatt
Period: September 2001–December 2005
Awardee: Abt Associates
Funding: $735,160
Description: The purpose of the quality monitoring project is to develop a quality monitoring process that meets the general goals of various global payment demonstrations including the Medicare Partnerships for Quality Cardiovascular Services and Medicare Partnerships for Quality Total Joint Replacement Services ("Quality Partnerships" for short and formerly referred to as the "Medicare Participating Centers of Excellence Demonstration") and, subsequently, to coordinate and implement that process. The process incorporates the identification and technical definition of appropriate performance measures, collection of data in a centralized database, the development and distribution of reports to provide meaningful information back to demonstration participants and CMS, and coordination of the quality consortia meetings and conferences. The Quality Partnerships Demonstration involves bundled Part A & Part B payments to premier cardiovascular and orthopedic facilities for selected procedures. The selected cardiovascular and orthopedic procedures include coronary artery bypass surgery, cardiac valve procedures, angioplasty, and knee and hip replacements. We expect that the use of global payments will align the incentives for efficiency between the hospitals and the physicians, thereby enhancing not only the efficiency, but the clinical quality of services. All of the selected demonstration sites are invited to participate in a specialty-specific "quality consortia" that develops quality criteria and quantitative measures for monitoring performance during the demonstration.

Status: As of December 2001, the contractor is preparing to submit the required reports on performance measurement for cardiovascular and total joint replacement procedures. They are also preparing a survey for demonstration sites regarding current system capabilities and relevant data collection activities. This contract will also be used to support other global payment and related demonstrations including the Provider Partnerships Demonstration and the New Jersey Hospital Association Demonstration. However, work related to these latter two demonstrations is on hold pending agency approval to proceed with implementation of the demonstrations.

02-051 Evaluation of the Medicare Preferred Provider Organization (PPO) Demonstration (Phase I and Phase II)
Project Officer: Victor McVicker
Period: September 2002–September 2007
Awardee: Research Triangle Institute, (DC)
Funding: $1,463,493
Description: The purpose of this project is to evaluate the Medicare Preferred Provider Organization (PPO) demonstration. A comprehensive evaluation will include a case study component to examine issues pertaining to the implementation and operational experiences of the PPOs as well as statistical analyses of secondary data, including individual level data, to examine issues of biased selection, and impacts on the use and cost of services. Primary data will be collected through site visits to participating plans and beneficiary surveys.
Status: Phase I (2002-2005), Phase II (2006-2007).

96-057 Case-Mix Adjustment for a National Home Health Prospective Payment System
Project Officer: Ann Meadow
Period: July 1996–May 2002
Awardee: Abt Associates
Funding: $3,955,955
Description: The primary focus of this study is to understand existing variation in home health resource patterns and to use this information to develop a case-mix adjuster for a national home health prospective payment system (PPS). Elements from the Outcome and Assessment Information Set (OASIS), which has been developed for quality improvement in Medicare home health agencies, are analyzed for their usefulness as measures within a case mix adjustment model. Additional detailed information, including information on resource utilization, has been collected from participating agencies. Ninety agencies were recruited and trained from eight States (Arkansas, California, Florida, Illinois, Massachusetts, Pennsylvania, Texas, Wisconsin) in the spring and summer of 1997. Data collection began in October 1997 and ended in the spring of 1999.
Status: The resulting case mix adjuster was incorporated in the Medicare home health PPS, which was implemented in October 2000. Selected OASIS items, collected at the start of each 60-day payment episode, are used for patient classification. An additional item on therapy utilization was added for purposes of the case mix model. The items fall into three major domains: clinical factors, functional-status factors, and utilization factors. Under modifications to the original contract, the project assumed additional tasks to 1) develop and test home health PPS grouper software, 2) provide technical assistance for setting PPS rates, 3) design and assist CMS in implementing an OASIS verification protocol for use

by regional home health fiscal intermediaries, and 4) develop data and conduct analyses to refine the initial case mix model. Results of the study to date are available.

00-023 Direct and Indirect Effects of the Changes in Home Health Policy and an Analysis of the Skill Mix of Medicare Home Health Services Before and After the Balanced Budget Act of 1997
Project Officer: Ann Meadow
Period: March 2000–September 2003
Awardee: Laguna Research Associates
Funding: $24,298
Description: This project provides partial support for a project primarily funded by the Robert Wood Johnson Foundation (RWJ). As part of this larger project, CMS supplies needed data and receives the results of a special study. The major (RWJ) project examines three areas where impacts of the Balanced Budget Act of 1997 (BBA) might fall: the Medicare beneficiary, home health care agencies, and the overall medical and long-term care system. Analysis based on the data CMS supplies under this award, taken together, will help understand the overall pattern of impacts and be useful in formation of future reimbursement policy. The special study for CMS looks at beneficiary access. This will analyze pattern of Medicare home health use before and after the implementation of the BBA. There is a focus on assessing whether changes occurred in the skill mix of types of visits received by home health users. It will examine whether differential effects have occurred for different categories of home health users and in different geographic areas.
Status: The data are being accessed after considerable delay at CMS. They are being prepared for analysis as of December 2000. Because of this delay in access to the information, the project was extended through March 2002.

94-087 Maximizing the Cost Effectiveness of Home Health Care: The Influence of Service Volume and Integration with Other Care Settings on Patient Outcomes
Project Officer: Ann Meadow
Period: September 1994–September 2002
Awardee: Center for Health Policy Research, University of Colorado
Funding: $1,496,245
Description: This study examines how to integrate home health care (HHC) with care in other settings to reduce overall health care costs. The central hypotheses of this study were that volume-outcome relationships are present in HHC for common patient conditions, that upper and lower volume thresholds exist that define the range of services most beneficial to patients, and that a strengthened physician role and better integration of HHC with other services during an episode of care can optimize patient outcomes while controlling costs. A sample of patient records were analyzed from agencies in 20 States stratified into high, medium, and low-volume categories based on annual visits per beneficiary, and patient health status and service information between HHC admission and discharge to assess patient outcomes and costs within the HHC episode was recorded. Long-term, self-reported outcomes were measured from telephone interview data at HHC admission and from 6-month followups. These primary data concerning patient status and outcomes were combined with Medicare claims data over the episode of care to study the relationship between service volume in HHC and both patient outcomes and costs.

Status: Four common conditions (congestive heart failure, stroke, surgical hip procedures, and open wounds) were studied. Two-sample tests for mean differences in case mix characteristics and volume were performed to compare the two volume groups within each condition. The median volume (defined as number of visits until discharge or first inpatient admission) differed by a factor of about four to nine, depending on the condition. For home health aide services, mean volume differed by a factor of between 30 and 47. Limitations in activities of daily living (ADLs) were significantly greater for the high-volume groups, these patients had a greater prevalence of chronic conditions, and their institutional utilization within the 14 days prior to admission was less likely to be an acute-care hospital, indicating the more post-acute nature of the low-volume groups. This general case mix difference is consistent with the greater use of aide services for high-volume patients. Preliminary analyses of outcomes suggested relatively few differences in outcomes by volume, after controlling for condition. This result may mean that the additional services delivered to the high-volume group helped equalize outcomes between more severely ill and less severely ill patients.

01-233 Studies in Home Health Case Mix
Project Officer: Ann Meadow
Period: September 2001–December 2005
Awardee: Abt Associates
Funding: $739,713
Description: The purpose of this project is to further develop the case mix model used for the home health PPS system implemented in October 2000, and to explore new approaches to case mix adjuster development. Some of the results may have near- or medium-term application to CMS rulemaking for Medicare home health payment because they are essentially extensions of the current model. Other results are not necessarily extensions of the current model and, therefore, might find application in the longer-term future. All work will be conducted using existing administrative databases.
Status: The project is in the early developmental stages.

99-057 Evaluation of Issues Related to Prospective Payment System under Consolidated Bidding for Skilled Nursing Facilities and Home Health Agencies
Project Officer: Cindy Murphy
Period: August 1999–June 2003
Awardee: Jing Xing Technologies
Funding: $938,370
Description: This project provides analytical support for CMS on operating issues (claims processing, medical review (MR) and data processing) for providers and contractors (intermediaries, carriers, and Durable Medical Equipment Regional Carriers (DMERC)) related to implementation of skilled nursing facility (SNF) Part A prospective payment system (PPS) consolidated billing under Parts A and B, and implementation of the new SNF Part B fee schedule.
Status: The report is available.

00-090 Behavior Validation to Decrease Problem Behaviors of Elderly with Advanced Dementia
Project Officer: Dennis Nugent
Period: September 2000–January 2002
Awardee: University of Missouri - Kansas City, Office of Research Administration
Funding: $250,000
Description: This project studies the effect of using behavior validation strategies to manage problem behaviors of nursing home elderly with dementia of the Alzheimer's type (DAT). The objectives are to determine if a program of behavior validation, used by nursing home caregivers, will decrease residents' behavior problems, and to explore the feasibility of integrating this program into orientation and staff education. The usual course of DAT disease progression is associated with problem behaviors (disruptive, inappropriate, and agitated), which occur in 20-90 percent of nursing home residents depending on the level of dementia. These behaviors are expensive in that they cause harm to staff and other residents; increase the use of chemical and physical restraints; increase staff dissatisfaction, absenteeism and turnover rates; and can even result in property damage. While some behavior management interventions have been shown to be effective, they are underutilized. Behavior validation consists of verbal and nonverbal responses to a behavior problem to calm the resident and redirect the behavior into one that is more favorable. Behavior education for staff addresses characteristics of problem behaviors and actions that are effective in behavior management.
Status: The project is complete and the final report is being drafted. The Principal Investigator has indicated that the report will be ready at the end of the award period.

97-005 Rebasing Prospective Payment System and Exempt Hospital & Skilled Nursing Facility Input Price Indices from Newly Available Sources
Project Officer: Stephen Heffler
Period: February 1997–September 2002
Awardee: Jing Xing Technologies
Funding: $592,265
Description: This project assists in the rebasing of the prospective payment system (PPS) and exempt hospital input price indexes, and the skilled nursing facility (SNF) input price indices using data from newly available sources. It will also assist in the study of the relationships between different health care payers in different health care settings and a determination of alternative methodologies for updating Medicare payments using prices, productivity, technology, and demographics. For the National Health Accounts, it will assist in the development of a time series of annual capital expenditures of fixed and movable equipment and a time series of annual expenditures for nursing home care and home health care in hospital-based nursing facilities and hospital-based home health agencies (HHAs).
Status: Most tasks have been completed, including rebasing the PPS and SNF input price indexes, estimating hospital-based SNF and HHA expenditures, reviewing alternative update methodologies, and using the Medicare Cost reports to estimate hospital payments and expenditures. Work is completed on estimating capital expenditures for the National Health Accounts.

00-067 Medicare Post-Acute Care: Evaluation of Balanced Budget Act Payment Policies and Related Changes
Project Officer: Philip Cotterill
Period: September 2000–September 2002
Awardee: MEDSTAT Group (DC)
Funding: $636,557
Description: The purpose of this project is to study the impact of Balanced Budget Act (BBA) and other policy changes on Medicare utilization and delivery patterns of post-acute care. Post-acute care is generally defined to include the Medicare covered services provided by skilled nursing facilities (SNFs), home health agencies, rehabilitation hospitals and distinct part units, long-term care hospitals, and outpatient rehabilitation providers. This initial project will compare changes between the pre-BBA period of the 1990's and the post-BBA year, 1999. The study will include a variety of beneficiary, provider, and market area analyses. Since the impacts of policy changes not yet implemented will continue to be of interest for many years, the analyses developed under this contract are expected to use and refine methods that can be applied in future evaluation research.
Status: Much of the first year of the project was spent constructing data sets.

00-094 Study of the Impact of Boren Amendment Repeal on Nursing Facility Services for Medicaid Eligibles
Project Officer: Paul Boben
Period: September 2000–March 2002
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
Funding: $268,875
Description: The purpose of this project is to study the impact of the repeal of the Boren Amendment on Medicaid beneficiaries' access to care in a nursing facility (NF), a hospital, or intermediate care facility for the mentally retarded (ICF/MR) and the quality of care available to them in those facilities. The study will examine rate setting methodologies to learn whether States have changed their methods of payment since the repeal of the Boren Amendment and whether these changes have affected access to care or quality of care received by Medicaid beneficiaries.
Status: In July 2001, the contract was modified to incorporate analyses of the impact of repeal of the Boren Amendment on hospitals and ICF/MR, in addition to the existing study focusing on NF. The period of performance was extended to March 30, 2002 to accommodate the additional work. A draft Report to Congress on the impact of Boren Amendment repeal on access to and quality of NF services was received in February 2001. Draft reports on hospitals and ICF/MR are expected by January 2002, and will be submitted to Congress as a follow-up report. A report of a multivariate analysis of the effect of Medicaid payment policies on the NF sector is also expected in 2002.

01-108 Assessment, Refinement and Analysis of the Existing Prospective Payment System for Skilled Nursing Facilities
Project Officer: Carolyn Rimes
Period: July 2001–July 2005
Awardee: Urban Institute
Funding: $6,383,566
Description: This project supports CMS in 1) the assessment of the feasibility of refining the current Medicare payment system for skilled nursing facilities and, if feasible, produce analyses that support these refinements and 2) our exploration of different systems for categorizing patients and their resource allocation. It will analyze data and prepare a report containing recommendations for possible revisions to the classification of patients in a manner that accounts for the relative resource use of different patient types. This project focuses only on the Medicare beneficiary population, including those beneficiaries defined as dually eligible.
Status: Phase I focuses on the design and creation of a data base. Phase II analyses support annual refinements to the payment system; and analysis, testing, simulations, and making recommendations regarding potential options for modifying, restructuring, or reconfiguring the existing patient classification and payment system for skilled nursing facilities.

98-239 Evaluation of Competitive Bidding Demonstration for DME and POS
Project Officer: Ann Meadow
Period: September 1998–May 2003
Awardee: University of Wisconsin - Madison
Funding: $2,315,249
Description: CMS has mounted a demonstration to test the feasibility and effectiveness of establishing Medicare fees for durable medical equipment (DME) and prosthetics, prosthetic devices, orthotics, and supplies (POS) through a competitive bidding process. The fundamental objective of competitive bidding is to use marketplace competition to establish market-based prices and to select DME suppliers. The Balanced Budget Act of 1997 (BBA) authorized competitive bidding demonstrations for Part B services (except physician services), and the current project is being conducted under that authority. The initial site of the demonstration is Polk County, Florida. A second site, San Antonio, Texas, was selected in 2000. Competitively bid product categories in Polk are oxygen supplies and equipment, hospital beds, enteral nutrition, surgical dressings, and urological supplies.
Product categories in Texas are oxygen supplies and equipment, hospital beds, manual wheelchairs, nebulizer drugs, and non-customized orthotics. Medicare contracts with winning suppliers in Polk County commenced in October 1999, and San Antonio contracts commenced in February 2001.
Status: A pre-demonstration survey of oxygen users and users of other medical supplies was fielded in two Florida counties (Polk and Brevard) in March 1999. The results suggested beneficiaries were highly satisfied with the services and products delivered by their Medicare suppliers. A followup survey, fielded in CY 2000, will provide data for the pre-test/post-test comparison design analyzing the impact of the demonstration in Polk County. The evaluation team conducted five site visits to Polk County in 1999 and 2000 as part of the project's case study activities addressing access, quality, and administrative and market outcomes. A baseline survey in two Texas areas, San Antonio and Austin-San Marcos, was fielded in 2000, and an initial site visit to Texas was conducted in late 2000. Other evaluation activities

include claims analyses, focus groups, fee-schedule analyses, and additional surveys. The first annual evaluation report to Congress is scheduled for release in early CY 2001. A paper analyzing the responses to the Polk County baseline survey has been submitted for publication.

94-131 Randomized Controlled Trial of Primary and Consumer-Directed Care for Persons with Chronic Illnesses

Project Officer: Tamara Jackson-Douglas
Period: September 1994–December 2002
Awardee: Monroe County Long Term Care Program, Inc.
Funding: $96,498

Description: This demonstration project was designed to determine the cost and effectiveness of providing consumer-directed care on the health status, quality of life, cost, and service use of community-dwelling Medicare beneficiaries who are chronically ill, functionally impaired, and at high risk for repeated hospital admissions. The demonstration uses three treatment models to test how well different models of care empower and inform the patient to make decisions on health care that are more cost-effective and lead to improved or sustained health outcomes. Outcomes are measured by hospital utilization; total health and long-term care costs; health and functional status; problematic behaviors; quality of life; caregiver stress and burden; and patient, caregiver, and physician satisfaction. This demonstration is located in two geographic areas: Monroe County, New York, and the mid-Ohio valley, which includes portions of northern West Virginia and southern Ohio.

Status: The project was originally approved in 1994; however, waivers were not approved for the three intervention groups until April 1997 due to the lengthy process of defining and re-defining the design of the demonstration. Although sites began enrolling patients in late 1996, enrollment did not begin in earnest until after the final waiver approval was secured, and full enrollment of the required 1600 chronically ill Medicare beneficiaries was not achieved until June 2000. Based on the 24-month treatment period, the last enrollees are to receive service through June 2002. Funding for the project concludes in December 2002, after six months of phase-down activities for the investigator teams, including final data analysis and report generation.

This project was granted several extensions in the past to account for delays associated with startup. In late 2001, the project's principal investigators requested an additional 12 months of waivered services and an additional $1.5 million to complete their evaluation. Their request was not approved.

CONSUMER DIRECTED DURABLE MEDICAL EQUIPMENT DEMONSTRATIONS

These demonstrations support the United States Department of Education's "Center for Independent Living" projects. A Center for Independent Living is a local consumer-led organization devoted to helping people with disabilities live and work within their communities. This CMS demonstration effort helps Medicare beneficiaries with disabilities exercise greater choice and control in meeting their personal needs for wheelchairs and other durable medical equipment. Goals of the projects include treating individuals with disabilities with dignity, providing the necessary tools to live and work more independently, and assisting people with disabilities to be successfully employed. CMS and the Department of Education will share any innovations and best practices identified under the demonstration projects.

01-286 Medicare Competitive Bidding Demonstration for Durable Medical Equipment, II
Project Officer: Mark Wynn
Period: August 2001–September 2002
Awardee: Palmetto Government Benefits Administrators
Funding: $715,000
Description: This demonstration project is being implemented to test the feasibility of obtaining lower prices through competitive bidding for selected lines of durable medical equipment, prosthetics, orthotics, and supplies. Suppliers selected as demonstration suppliers are the only ones eligible to receive Medicare payments for supplying the products covered by the demonstration. Demonstrations are being implemented in two metropolitan areas--Polk County, Florida and the San Antonio, Texas Metropolitan Statistical Area (MSA). The supply lines that were offered for competitive bidding at the Florida site are: 1) home oxygen therapy; 2) hospital beds and accessories; 3) enteral nutrition therapy; 4) surgical dressings; and 5) urological supplies. The supply lines that were offered for competitive bidding at the Texas site are: 1) hospital beds and accessories, 2) home oxygen therapy, 3) manual wheelchairs and accessories, 4) noncustomized orthotics, and 5) nebulizer inhalation drugs.
Status: The first demonstration site became operational in October 1999 in Polk County Florida. Sixteen suppliers were selected as "Demonstration Suppliers" for one or more of the covered product categories. The new rates took effect in October 1999 and remained in effect for 2 years. A second round of bidding took place in Polk County in 2001 to determine the prices for the final year of the project. The second demonstration site became operational in February 2001 in the San Antonio, Texas MSA. The new rates took effect in February, 2001 and will remain in effect through 2002.The average savings at the two demonstration locations was 20 percent, as compared with the Medicare fee schedule.

99-081 Developing and Evaluating the Use of a Quality Indicator Format in the End Stage Renal Disease Survey Process
Project Officer: Judith Kari
Period: September 1999–June 2003
Awardee: Lewin Group
Funding: $466,231
Description: The purpose of this project is to develop, test, and describe improved processes and formats for enhancing the survey process for End Stage Renal Disease (ESRD) facilities. An improved survey process would include effectively using quality indicators in the survey process, developing more consistent and accurate survey results, and developing more efficient and objective ways to record survey results.
Status: The progress on this project has been suspended since February 2000.

99-042 Validation of Physician Time Data
Project Officer: Jim Menas
Period: August 1999–March 2002
Awardee: Health Economics Research
Funding: $460,668
Description: The project focused on the validity of the current time estimates for certain high volume codes paid under the Medicare Physician Fee Schedule. One of the tasks developed alternative sets of

services for validation. The project evaluated alternative sets of criteria, including high volume, high volume per specialty, low absolute time estimates, and reference set services. It also constructed time estimates for codes using three different secondary data sets. The three data sources on which analyses were conducted were the Medical Group Management's Profiling Data Base, D. J. Sullivan Operative Time Data Base, and National Ambulatory Medical Care Survey (NAMCS).
Status: The final report on the NAMCS data and the D.J. Sullivan Operative Time Database are available from the CMS Web site as of January 2002. A second report on MGMA's Profiling Database and additional selected codes from the D.J. Sullivan Database was completed in March 2002.

99-045 Study of Medicare Payments in Health Professional Shortage Areas
Project Officer: William Buczko
Period: September 1999–May 2002
Awardee: RAND Corporation
Funding: $327,326
Description: This project compiles data on trends in Medicare service utilization and payments in rural areas, Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) over the past decade. It examines the distribution of Medicare payments to HPSAs/MUAs for services provided in, or to residents of, these areas. This project will also assess the adequacy of these geographic designations and special payments and examine possible geographic designation and Medicare rural payment policy reforms.
Status: Analyses of substitution of Rural Health Center visits for physician office visits, the relationship between primary care services and avoidable hospitalizations, and alternative methods for classifying rurality and the project final report was due May 2002.

00-116 Design, Development, and Implementation of an Improved Medicare Outpatient End Stage Renal Disease Prospective Payment System
Project Officer: William Cymer
Period: September 2000–March 2002
Awardee: Michigan Public Health Institute
Funding: $380,038
Description: This project is the first phase of a research effort to design, develop, test, and aid in the implementation of an improved Medicare outpatient end stage renal disease prospective payment system (ESRD PPS). This phase will identify, describe, and evaluate the adequacy of relevant CMS databases for the development of a bundled outpatient ESRD PPS. In a bundled PPS, all outpatient renal related services, tests, drugs, and supplies would be incorporated into a fixed reliable payment rate. Differences in patient specific case-mix that can be associated with legitimate differences in resource consumption would be reflected in differences in payment. This study is necessary to determine whether a case-mix measure might be appropriate under a bundled outpatient ESRD PPS.
Status: Based on findings from this first phase of research, the project assesses whether CMS databases permit the construction of clinically and statistically coherent case-mix measures predictive of provider differences in Medicare costs in a bundled outpatient ESRD PPS.

99-032 Practice Expense Methodology
Project Officer: Ken Marsalek
Period: May 1999–May 2004
Awardee: Lewin Group
Funding: $374,953
Description: This project provided technical assistance to evaluate various aspects of the practice expense methodology for the Medicare Physician Fee Schedule.
Status: An evaluation of the 1998 questionnaire and an initial review of the methodology of the practice expense per hour values derived from the data was completed. Recommendations regarding the practice survey design and methodology and considering how the practice-level survey could be used and how the information could be cross-walked to the socioeconomic monitoring system survey are available. In addition, medical specialty organizations reviewed and made recommendations.

99-034 Describing and Assessing the Implication of Developing and Implementing a Prospective Payment System for Long Term Care Hospitals
Project Officer: Carolyn Rimes
Period: June 1999–March 2002
Awardee: Urban Institute
Funding: $1,805,764
Description: This project evaluates a Prospective Payment System for Long Term Care Hospitals (PPS) and has provided analyses in support of Part B Therapy Services under Medicare. The project involves the construction of a database describing and analyzing the universe of long-term care hospitals (including any units subsequently defined/certified or licensed as long-term care hospitals) in terms of: facility characteristics, beneficiary use, beneficiary characteristics including diagnoses, referral, transfer and discharge patterns and relationship of these facilities with acute care and other care providers, including skilled nursing facilities (), home health agencies () and rehabilitation hospitals. Information from the database will be used to describe and analyze the long-term care hospitals and their interrelationship with other components of the health care system. Discharge diagnoses from long-term care and acute-care hospitals, including a detailed analysis of the treatment patterns for patients; International Classification of Diseases, 9th Revision, Clinical Modification codes; and age, gender, and disposition codes, including principal and additional diagnoses and procedural codes, will be analyzed.
Status: Analyses on the long term care hospitals has been completed. The work assessing the relationship between the outpatient therapies, specifically the impact of extending fee schedule payments and coverage limits, has been completed and is available. Additional analyses on Part B therapy services under Medicare is ongoing. The analysis on home heath is ongoing.

99-038 Design, Development, Implementation, Monitoring & Refinement of a Prospective Payment System for Inpatient Rehabilitation
Project Officer: Carolyn Rimes
Period: July 1999–September 2004
Awardee: RAND Corporation
Funding: $5,908,651
Description: The purpose of this project was to support the design, develop, implement, monitor, and refine a case-based prospective payment system for rehabilitation facilities providing services to Medicare beneficiaries. Phase I of this project has been completed. This research has supported the development of a PPS for inpatient rehabilitation. This included the assessment and development of a classification system based upon both UDSmr and MEDIRISK data and focused on the Medicare population. The project will assess the feasibility of including or considering additional MDS PAC variables, and assess the potential impact of the FIM-FRG classification system and subsequent payment system. Phase II of this contract will be creating a national data base merging the Inpatient Rehabilitation Facility Patient Assessment Instrument with CMS administrative data to analyze the case mix groups and the facility adjustments for refinements to the payments systems, as well as analysis of special cases i.e., day and cost outliers, short stay, deaths, transfers and interrupted stay. Phase II will create and assist CMS in developing a monitoring system to assess the impact of the inpatient PPS and analyze the results of the staff time measurement study to assess compression. Additional tasks that will be addressed in the second phase of this contract include: impact of specific departments within the facilities or exempt units, assessment of technological innovations' impact on functional groups or the payment system, analysis of ADLs to predict disability status and payment, and continued analysis of the impact of motor and cognitive variables on predicting disability status and payment. This phase will continue to analyze the impact of impairment groups, with and without comorbidities, and analyze the impact of comorbidities and their relationship to RICs and complexities.
Status: A work plan and interim report on "Inpatient Rehabilitation Facility Prospective Payment System" for Phase I is available. The Phase II work plan is under review.

99-062 Hospital Outpatient Prospective Payment System: Development of Volume Performance Standards and a Hospital Outpatient Market Basket
Project Officer: Barbara Lutz
Period: September 1999–January 2002
Awardee: Health Economics Research
Funding: $410,303
Description: This project helped CMS construct a market basket specific to hospital outpatient services so that the market basket can be used to annually update the payment rates for outpatient services under prospective payment system (PPS), including partial hospitalization services in Community Mental Health Centers (CMHCs). The project helped determine a feasible long-term methodology for controlling unnecessary volume increases in hospital outpatient services and in partial hospitalization services furnished in CMHCs paid under the hospital outpatient PPS. With the exception of ambulance and outpatient rehabilitation services, which are subject to separate fee schedules, the law provides the authority to determine which services are included under the hospital outpatient PPS.
Status: This project was completed.

97-201 Municipal Health Services Program:
Project Officer: Ronald Deacon
Period: June 1978–December 2004
Awardee: City of Baltimore
Funding: $0
Description: This Municipal Health Services Program (MHSP) is a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and CMS. CMS provides Medicare and Medicaid waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care. Waivers and grants were awarded to Baltimore, Cincinnati, Milwaukee, and San Jose in June 1978.
Status: Congress extended the demonstration several times: The Balanced Budget Act of 1997, extended the demonstration until December 31, 2000 It also mandated a transition plan limiting any new enrollment and providing a smooth transition from demonstration to non demonstration status. The Balanced Budget Reconciliation Act of 1999 extended the transition phase until December 31, 2002, and the Medicare Benefits Improvement and Protection Act of 2000 again extended it until December 2004. A review of the cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, e.g., prescription drugs, dental care, and vision care.

01-279 Consultation and Assistance with Evaluation of the Medigap Monitoring Demonstration Grants
Project Officer: Marcia Marshall
Period: September 2001–December 2002
Awardee: L. Sue Anderson
Funding: $19,850
Description: This project provides support to intramural staff to evaluate the results of the Medigap Monitoring Demonstration Grants; projects being awarded in fiscal year 2001. These demonstrations collect information, monitor, and report on market conduct and violations by issuers of Medicare supplemental insurance–Medigap Insurance. The project will work with the Medigap Monitoring grant project officer to review reporting requirements and determine a process and methodology to proceed with reporting on the activities of the demonstrations, and to facilitate evaluation. It will also process and summarize the demonstration grant reports and the 3-, 6- and 9-month marks. Finally, it will evaluate the effectiveness of each of the demonstrations and compare each to the others for a final evaluation.
Status: The project is newly underway.

99-048 Design and Simulation of Alternative Medigap Structure
Project Officer: John Robst
Period: September 1999–February 2002
Awardee: Lewin Group
Funding: $588,984
Description: The project compiled premium data on existing standard Medigap premiums, formulated alternative standard benefit packages, and estimated premium costs of these alternative packages. From this analysis, the current and alternative Medigap options were compared. Despite many changes in the Medicare program since the early 1990s, the basic benefit structure of Medicare supplemental insurance has remained unchanged. This project examined possible updated Medigap benefit structures, and compared these alternatives to the premiums and benefit structures of currently available supplementary coverage, as well as Medicare+Choice options.
Status: Collection of existing standard Medigap premiums from insurance carriers and State insurance commissioners is nearing completion.

00-118 Retiree Health Benefits
Project Officer: Brigid Goody
Period: September 2000–June 2002
Awardee: University of Wisconsin - Madison
Funding: $249,971
Description: This project examines current employer-based health insurance coverage for Medicare-eligible retirees, the prospects for continuation of this coverage, and possible implications for the restructuring of the Medicare fee-for-service (FFS) and Medicare+Choice (M+C) programs. Although approximately one-third of aged Medicare beneficiaries have coverage under an existing employer-sponsored health insurance policy, the prevalence of coverage has declined and retiree cost-sharing requirements have increased in recent years. The project will consist of two parts. The first part will analyze existing secondary data to describe the types of coverage offered to Medicare-eligible retirees, the funding for this coverage, and recent trends in coverage. The second part will be comprised of interviews aimed at understanding the prospects for future employer-sponsored coverage of this population, possible impacts of Medicare reform initiatives on this coverage, and how the Medicare program, both FFS and managed care, might be restructured to encourage continued coverage.
Status: The contractor has completed the first phase of the study and submitted a draft interim report. The interim report presents their analysis of the Kaiser Family Foundation/Health Research and Education Trust and the Medicare Current Beneficiary surveys. Key findings include:

- Availability of retiree health coverage has been fairly constant in recent years.
- There are differences in subgroups of beneficiaries with and without retiree coverage. White non-Hispanic beneficiaries with higher education and income, and who are married, are significantly more likely to have employer-sponsored insurance.
- In contrast to active employees, indemnity plans still constitute the dominant source of insurance coverage for retirees.
- Nearly all retiree health plans provide some form of prescription drug coverage.
- Only a small percentage of employers are considering changes to their retiree health benefits.

02-063 Evaluation of Wheel Chair Purchasing in the Consumer-Directed Durable Medical Equipment (CD-DME) Demonstration and Other Fee-For-Service and Managed Care Settings
Project Officer: William Clark
Period: September 2002–September 2004
Awardee: Abt Associates
Funding: $294,852
Description: The purpose of this task order is to conduct a preliminary case-study evaluation of a four-site initiative. The descriptive evaluation will compare and contrast the purchasing of wheelchair equipment in these sites with those utilized in fee-for-service and in managed care models, which serve people with disabilities. The study will propose further evaluation design options for CMS consideration. This initiative tests, at a local level, an important collaboration between the Department of Health and Human Services and the Department of Education intended to improve beneficiary access and satisfaction with the purchase and maintenance of wheelchair equipment.

02-065 Healthy Aging: Senior Risk Reduction Program
Project Officer: Pauline Lapin
Period: September 2002–November 2003
Awardee: MEDSTAT Group (DC)
Funding: $996,590
Description: The Senior Risk Reduction Program (SRRP) demonstration will test a new approach to health promotion using health risk appraisal programs. The goal is to determine if national implementation of the SRRP as a new Medicare program reduces health risks, improves self-efficacy, is cost neutral or saving, and whether participants report high levels of satisfaction with such a program.

02-061 The Impact of Prescription Drug Coverage on Medicare Program Expenditures: A Case Study of the Evaluation of the United Mine Workers' Demonstration
Project Officer: Jennifer Shapiro
Period: September 2002–September 2003
Awardee: Abt Associates
Funding: $181,763
Description: The purpose of this project is to conduct preliminary analytic work to explore the feasibility of identifying a control group using Medicare administrative data to assess the impact of comprehensive prescription drug coverage on Medicare Part A and Part B expenditures.

01-053 Iowa Senior Discount Prescription Drug Demonstration Project
Project Officer: Ronald Deacon
Period: March 2001–September 2002
Awardee: Iowa, Department of Public Health
Funding: $1,000,000
Description: This demonstration project uses a mercantile prescription drug purchasing cooperative or non-profit "buying club" corporation to reduce the burden of prescription costs on Iowa seniors. Approximately 274,000 seniors 65 or older do not have an insured drug benefit and are not enrolled in Medicaid. The 2001 budget contains a line for an award ($1,000,000) for this project. The State plans to implement the project in late 2001. The co-op/buying club negotiates discounts or rebates with pharmaceutical companies for the cost of the drug and discounts that are passed along to the consumer. The project supports beneficiary's choosing a lower cost but therapeutically equivalent medication if recommended by a physician or pharmacist. The key elements of the demonstration include marketing, pharmacist involvement, senior pledge/commitment, pharmacy benefit manager, pharmaceutical and therapeutics committee, physician involvement, education, and drug utilization review.
Status: The 2001 budget contains a line for an award ($1,000,000) for this project. Iowa requested and received an additional $500,000 from CMS to partially subsidize the enrollment fee, lowering it from $40 to $20. The project began enrollment in the Fall 2001 and operation in January 2002.

00-115 Assessment of Medicare Prescription Drugs and Coverage Policies
Project Officer: Brigid Goody
Period: September 2000–July 2002
Awardee: Research Triangle Institute, (NC)
Funding: $202,527
Description: The purpose of this project is to assemble and analyze recent fee-for-service and managed care plan data on Medicare spending for prescription drugs, as well as comparable data from other public and/or private payers. Using these data, the project will estimate possible financial effects of alternative Medicare payment policies for drugs currently covered by statute. This study will estimate current expenditures and possible savings from alternative reimbursement policies based on different discount rate and price schedules used by other payers, as well as examine other purchasing polices including competitive bidding and rebate mechanisms.
Status: This project was completed in July 2002.

99-035 Analysis of Medicare Beneficiary Baseline Knowledge Data Using MCBS
Project Officer: Sherry Terrell
Period: June 1999–June 2002
Awardee: University of Wisconsin - Madison
Funding: $229,123
Description: The purpose of this project was to analyze Medicare beneficiary baseline program knowledge data collected through the Medicare Current Beneficiary Survey (MCBS) in CY 1995-1997 and CY 1998 to determine data usefulness for program evaluation. The program objective was to evaluate National Medicare Education Program (NMEP) print material (Handbook: 1999 and Bulletin) and selected information distribution channels (print, Internet, 1-800-MEDICARE). The policy

objective was to support HCFA strategic plan initiatives, contribute to Government Performance and Results Act program performance reporting, and provide feedback for monitoring and continuous quality improvement of NMEP informational materials directed to the Medicare population over time.
Status: This project has been completed. In Phase I data analyses, several working measures of beneficiary Medicare program knowledge were constructed, validated and used to develop MCBS supplemental knowledge questions. In the Phase II analyses of CY 1998 data, these knowledge indexes were used to compare beneficiaries' program knowledge across program and policy variables of interest. Although only 24 percent of respondents reported reading all or some of the Medicare&You 1999 Handbook or Bulletin, these beneficiaries had significantly higher program knowledge scores, approximately 5 to 7 percentage points, than did those who did not read the handbook (bulletin). For each of the NMEP goals examined-access, awareness, understanding, and use–reading the 1999 handbook made a difference. Paper copy and microfiche copies of the final reports may be ordered from the National Technical Information Service by referencing the following NTIS accession numbers:- Analysis of Medicare Beneficiary Baseline Knowledge Data from the Medicare Current Beneficiary Survey: Knowledge Index Technical Note" (May 2000) PB2001-102026- Analysis of Baseline Measures in the Medicare Current Beneficiary Survey for Use in Monitoring the National Medicare Education Program: Final Phase One Report (November 2000) PB2001-104030.- Analysis of the 1998 Medicare Current Beneficiary Survey for Use in Monitoring the National Medicare Education Program: Phase Two Final Report (December 2000) PB2001-102747.Electronic copies of the above reports are also accessible from the CMS web page at http://www.cms.hhs.gov/ researchers/projects/.

95-089 State of Minnesota Senior Health Options (MSHO) Project
Project Officer: Susan Radke
Period: April 1995–December 2004
Awardee: Minnesota, Department of Human Services
Funding: $0
Description: In April 1995, the State of Minnesota was awarded Medicare and Medicaid waivers for a 5-year demonstration designed to test delivery systems that integrate long-term care and acute-care services for elderly dual eligibles. Under this demonstration, the State is being treated as a health plan that contracts with CMS to provide services, and provides those services through subcontracts with three health care plans. The State targets the elderly dually-entitled and Medicaid eligible only population that reside in the ten county St Paul/Minneapolis metropolitan area. Elderly Medicaid eligibles required to enroll in the State's current section 1115 Prepaid Medical Assistance Program (PMAP) demonstration have the option to enroll in the Minnesota Senior Health Options (MSHO) Project. The MSHO project provides additional long-term care and Medicare benefits to basic PMAP benefits. The State is continuing its current administration of the Medicaid-managed care program while incorporating some Medicare requirements that apply directly to the health plans with which the State would subcontract for MSHO.
Status: CMS approved the State 's request to extend MSHO and expand eligibility criteria to include persons under the age of 65 with disabilities. The expansion program titled, Minnesota Disability Health Options Program (MnDHO) and includes both disabled dual eligible beneficiaries and Medicaid eligible only beneficiaries. Administration of this program is similar to MSHO and the State currently contracts

with one health plan to provide services to the disabled population. The MSHO extension and MnDHO expansion are approved through the period of October 2001 through December 2004.

97-218 Multi-State Evaluation of Dual Eligibles Demonstrations
Project Officer: Noemi Rudolph
Period: September 1997–September 2005
Awardee: University of Minnesota, (Wash Ave)
Funding: $5,623,414
Description: This evaluation is designed to assess the impact of dual eligible demonstrations in the States of Minnesota, Wisconsin and New York. Analyses will be conducted for each State and across States. The quasi-experimental design will utilize surveys, case studies, and Medicare and Medicaid data for analysis. Major issues to be examined include the use of a capitated payment strategy to expand services while reducing/controlling costs, the use of case management techniques and utilization management to coordinate care and improve outcomes, and the goal of responding to consumer preferences while encouraging the use of noninstitutional care. A universal theme to be developed is the difference between managing and integration.
Status: Surveys of beneficiaries and their families have been completed in Minnesota and Wisconsin. The surveys gathered information on several areas including satisfaction, the use of formal and informal care, and informal caregiver burden. Three Annual Reports and two case study reports have been submitted to CMS. The New York demonstration received its waivers in September 1999 and is still working through pre-implementation issues prior to the start of enrollment. Due to the delay in implementing the dual eligible demonstrations within the scope of this project, the period of performance was extended at no cost to the government from September 2002 through September 2005.

98-202 Multi-State Dual Eligible Data Base and Analysis Development
Project Officer: William Clark
Period: September 1997–September 2002
Awardee: Mathematica Policy Research, (Princeton)
Funding: $2,135,418
Description: This project will use available Medicare/Medicaid-linked Statewide data in 10-12 States to develop a uniform database that can be used by States and the Federal government to improve the efficiency and effectiveness of the acute- and long-term-care services to persons eligible for both Medicare and Medicaid (dual eligible). It will also conduct analyses derived from these data to strengthen the ability to develop risk-adjusted payment methods and deepen the understanding of Medicare-Medicaid program interactions as they relate to access, costs and quality of service. Finally, it will recommend longer-range options that will improve the usefulness of the database for operational and policy purposes.
Status: The project is constructing a multi-State dual eligible database and using these data for analyses. Two years of the database have been constructed. However, the third year of Medicaid data has been unavailable for inclusion in the database due to problems external to this contract. Preliminary descriptive reports are being prepared with the 2 years of data, and research studies continue.

99-041 Case Studies of Managed Care Arrangements for Dual Eligible Beneficiaries
Project Officer: William Clark
Period: August 1999–February 2002
Awardee: Health Economics Research
Funding: $367,135
Description: The purpose of this project is to obtain greater knowledge of the dynamics of Medicare and Medicaid coordination of eligibility, benefits, and services at the health plan level. It will provide preliminary identification of issues that CMS, States, health plan contractors, and beneficiaries should prioritize and address. It will identify exemplary and routine approaches implemented by health plans for further consideration and potential adoption by others. Four market areas were selected for the studies: Portland, Oregon; Philadelphia, Pennsylvania; Miami, Florida; and Los Angeles, California. Beneficiary focus groups also will be convened to obtain beneficiary perceptions and experiences in using Medicare and Medicaid benefits in their managed care plans.
Status: Focus group activities in 2001 are completed.

01-142 Medicare Behavioral Health Cost and Use Study
Project Officer: James Hawthorne
Period: July 2001–July 2002
Awardee: Abt Associates
Funding: $244,659
Description: This project is developing a systematic process for monitoring Medicare expenditures for beneficiaries with behavioral health disorders. Information from the Medicare Enrollment Data Base (EDB) and from Medicare claims files will be used to identify and categorize beneficiaries in terms of relevant indicators of behavioral health problems. Utilization and expenditures for these beneficiaries will then be compared to those of other Medicare beneficiaries.
Status: At present, the project focuses only on Medicare expenditures. Subsequent projects however, will include an examination of Medicaid expenditures for dually eligible beneficiaries and the relationship between both Medicare and Medicaid expenditures and disability status under the Social Security Disability Insurance program.

02-062 Implementation of the READII Survey
Project Officer: Susan Arday
Period: September 2002–September 2003
Awardee: Abt Associates
Funding: $350,000
Description: CMS and the Centers for Disease Control and Prevention (CDC) are working with five demonstration sites to improve influenza and pneumococcal vaccination rates in African-American and/or Hispanic communities. This contract will implement the READII Survey to a sample of Medicare beneficiaries randomly selected from each of the five demonstration sites. Information will be collected via a telephone survey to evaluate the impact of the Racial and Ethnic Adult Disparities in Immunization Initiative. The demonstration sites use a coalition of public health professionals and medical providers to develop a community-based plan that will identify African-American and Hispanic individuals, who are 65 years of age and older in need of influenza and pneumococcal vaccinations, and offer these

immunization services to them. The five demonstration sites are: Chicago, IL, Bexar County, TX, Milwaukee, WI, Monroe County, NY, and selected counties in rural Mississippi.
Status: The five demonstration sites are: Chicago, Illinois; Bexar County, Texas; Milwaukee, Wisconsin; Monroe County, New York; and selected counties in rural Mississippi.

01-151 Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities Project
Project Officer: Diane Merriman
Period: September 2001–November 2002
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
Funding: $835,533
Description: The purpose of this project is to identify promising models of cancer prevention, detection and comprehensive care that promote health and appropriate utilization of Medicare covered services, in order to help eliminate health care disparities among Medicare beneficiaries. This project will evaluate best practices in the private sector, community programs, and academic research. Emphasis is being placed on interventions that promote primary prevention, such as programs that influence behavioral risk factors; secondary prevention interventions that promote the use of clinical preventive and screening services; and interventions that may include treatment. CMS plans at least 9 demonstration projects in specified target groups for the purpose of developing models and evaluating methods that: 1) improve the quality of items and services; 2) improve clinical outcomes, satisfaction, quality of life, and appropriate use of Medicare-covered services and referral patterns; 3) eliminate disparities in the rate of preventive cancer screening measures; and 4) promote collaboration with community-based organizations to ensure cultural competency of health care professionals and linguistic access for persons with limited English proficiency.
Status: The "Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities Project" is a multi-year project that has two phases. The first phase involves producing an evidence report that will synthesize evidence/best practices on intervention models that promote primary and secondary prevention interventions among the targeted ethnic and racial minority populations. The focus of these reports will be the interventions; i.e., what steps, conditions or actions are necessary for success, and their relevance to the Medicare program. The second phase involves the design and implementation of behavioral risk factor reduction and health promotion demonstrations.

00-092 Examining Gender and Racial Disparities Among Medicare Beneficiaries with Chronic Diseases
Project Officer: Marsha Davenport
Period: September 2000–March 2002
Awardee: Health Economics Research
Funding: $177,442
Description: This project is an analytic study using the Medicare administrative claims files to expand CMS' knowledge base in the area of women's health and chronic diseases. Findings from this project will assist CMS in targeting policies, programmatic changes, education, outreach, and research and demonstration projects to achieve improved health outcomes for female Medicare beneficiaries. Diseases such as arthritis, asthma, chronic obstructive

pulmonary disease (COPD) and other respiratory conditions, cancers, diabetes, heart disease, hypertension, osteoporosis, and stroke comprise the major categories of chronic conditions affecting persons age 65 and older. For women, cardiovascular disease is responsible for more deaths than almost all of the leading causes of death, including cancer. Recent studies have identified disparities in treatment for heart disease both by gender and race/ethnicity. There are a growing number of racial and/ethnic groups in this country who appear to be disproportionately sharing the burden of these chronic diseases.
Status: Analysis on stroke (hemorrhagic; ischemic; and transischemic attacks) and co-morbid diseases is in progress.

00-069 Health Disparities: Longitudinal Study of Ischemic Heart Disease Among Aged Medicare Beneficiaries
Project Officer: Linda Greenberg
Period: September 2000–September 2002
Awardee: Health Economics Research
Funding: $282,157
Description: The purpose of this project is to assess the use of Medicare covered services among Medicare beneficiaries with ischemic heart disease (IHD) based on sociodemographic characteristics (e.g., race/ethnicity, sex, age, socioeconomic status). This is being done using a longitudinal database comprised of 1997-1999 data that links Medicare enrollment and claims data with small-area geographic data on income (e.g., U.S. Census data or other private data sources). The advantage of a longitudinal database is that it provides data at multiple time points during a person's life. Information is being used to compare the incidence of disease and the outcomes of diagnostic and surgical procedures for IHD across racial/ethnic groups, socioeconomic status, and geographic areas. The unique aspect of this contract is that it examines cardiovascular care among Whites, Blacks, Hispanics, Asians, and American Indians/Alaskan Natives. This project addresses a HHS initiative to eliminate health disparities, which is one of the goals of Healthy People 2010.
Status: A Final Design and Analytic Report was completed in June 2001. Using the longitudinal Part A database, a draft report on provides preliminary results including data on admission rates, mortality rates, readmission rates, and inpatient procedure rates for IHD patients. It also characterizes the types of hospitals IHD patients go to when first admitted for IHD. This report is the first in a series of reports.

00-121 Health Status and Quality of Life for Women with Diabetes: Data from the Medicare Current Beneficiary Survey
Project Officer: Alberta Dwivedi
Period: September 2000–September 2002
Awardee: CHD Research Associates
Funding: $92,490
Description: This project develops a database, creates analytic files, and provides programming and analytic support for studies on beneficiaries with diabetes from the Medicare Current Beneficiary Survey (MCBS). These studies will focus on gender and racial/ethnic differences for respondents in the

MCBS who reported having had a diagnosis of diabetes. Through creating a database and analytic files, studies on Medicare beneficiaries with diabetes can be conducted using several years of data from the MCBS. Important issues related to health, health status, co-morbid conditions, functional status, disability, and quality of life, as well as costs and utilization of health care services, can be examined.
Status: Preliminary descriptive data analyses, both unweighted and weighted, were completed for the demographic characteristics of beneficiaries with diabetes from MCBS. Additional analyses are planned to compare the persons with diabetes to beneficiaries without diabetes on such variables as risk factors, activities of daily living and instrumental activities of daily living, co-morbid diseases, medications, and use of preventive services. Future analyses will also include data from the Medicare claims files to study the use of appropriate services for the management of diabetes.

02-054 Health Disparities: Measuring Health Care Use and Access for Racial/Ethnic Populations
Project Officer: Linda Greenberg
Period: September 2002–September 2003
Awardee: Research Triangle Institute, (DC)
Funding: $284,870
Description: The purpose of this project is to analyze health care access trends among minority beneficiaries and determine whether and the extent to which health care disparities exist among minority populations including those who have not previously been studied using Medicare data. In addition, this project will focus on examining the accuracy and completeness of race/ethnicity data in the Medicare enrollment database.
Status: This project is in the startup phase.

00-122 Development and Production of the Medicare Quality Monitoring System
Project Officer: Benedicta Abel-Steinberg
Period: September 2000–September 2002
Awardee: Health Economics Research
Funding: $1,173,065
Description: The CMS Medicare Quality Monitoring System (MQMS) tracks various aspects of the health status and health care of the Medicare beneficiaries using a combination of survey and administrative data. The primary goal of the MQMS is to collect, analyze, and interpret national and/or State-specific health data (both surveys and administrative data) on service utilization, health status and outcomes on morbidity and mortality relevant to CMS' Health Care Quality Improvement Project (HCQIP). The secondary goal is to disseminate the health and quality of care data/information to support quality of care improvement efforts and to promote HCQIP-related studies. Specifically, this effort produces two sets of data and information. One exhibits the trends, patterns and variations of service utilization and health status of Medicare beneficiaries, while the other exhibits the trends, patterns and variations of specific health outcomes relevant to HCQIP.. The MQMS is designed to fully address issues of disease-specific health status and outcomes of care at the State level, and are relevant to program improvement and accountability of the HCQIP.
Status: HCQIP initially focused on acute myocardial infarction (AMI); however, CMS expanded its national quality improvement activities and is focusing on six clinical priority areas: AMI, breast cancer, diabetes, heart failure, pneumonia, and stroke.

98-251 Measurement, Indicators, and Improvement of the Quality of Life in Nursing Homes
Project Officer: Mary Pratt
Period: June 1998–May 2002
Awardee: University of Minnesota, School of Public Health
Funding: $2,766,715
Description: This project evaluates the impact of providing additional knowledge and educational tools on the improvement of quality of life for nursing home residents. It will focus on three topics: 1) measuring and developing indicators of quality of life, 2 developing quality improvement programs for nursing home quality of life, and 3) evaluating environmental design influences on quality of life. The 11 domains initially tested include: autonomy, dignity, individuality, privacy, enjoyment, meaningful activity, physical comfort, relationships, security, functional competence, and spiritual well-being.
Status: Data analysis is underway to examine the inter-temporal and inter-rater reliability of the measures, test the transferability of the measures to nursing home personnel, and develop and test indicators of quality of life in nursing homes. In addition, the project is developing reliable ways to describe and classify features of the physical environment in nursing homes so as to study how physical environments affect quality of life.

97-264 Research and Analytic Support for Implementing Performance Measurement in Fee-for-Service
Project Officer: Peggy Parks
Period: September 1997–April 2002
Awardee: Health Economics Research
Funding: $1,151,985
Description: The goal of this project is to provide comparable information regarding performance in managed care and fee-for-service (FFS) programs. The project evaluated performance measurement at the national and small geographic area levels and practitioner-specific performance measurement at the group practice level. The small areas correlate with managed care market service-area definitions. Five small geographic areas were selected in Arizona, Georgia, Pennsylvania, Wisconsin, and Washington. Within those small geographic areas, four group practices agreed to participate in this project as our study partners. The study partnerships assisted us in exploring the feasibility of producing these measures at the group practice level.
Status: The project is nearly completed. In 2002, the contractor will submit reports on the Health Outcomes Survey in Medicare Fee for Service and a comparison of it with the Health Outcomes Survey in Managed Care. A report on how responses to the survey can be biased was recently submitted.

00-065 Clinical and Economic Effectiveness of a Technology-Driven Heart Failure Monitoring System
Project Officer: John Pilotte
Period: September 2000–September 2004
Awardee: University of Pennsylvania, Heart Failur and Cardiac Transplant Program
Funding: $1,688,453
Description: This demonstration project assesses the impact of the Alere DayLink Heart Failure Monitoring System on the clinical outcome and economic effect among Medicare beneficiaries recently

hospitalized for heart failure or acute exacerbation of previously existing heart failure. The project first looks at the addition of the Alere DayLink Heart Failure Monitoring System to standard management of heart failure medical care impact on re-hospitalizations for heart failure over six months. Second, the project will analyze the impact of the monitoring system on utilization of other Medicare services, Medicare costs, functional status, processes of care, physician adherence to recommended clinical care guidelines, patient adherence with prescribed therapy, social support, and patient acceptance and satisfaction. Patients initially randomized to this technology will be re-randomized to either an additional 6 months of monitoring or to standard heart failure medical care with discontinuation of the Alere telemonitoring to assess the persistence of the intervention's effectiveness. Third, analysis will explore the impact of the extended six months of this monitoring system on re-hospitalization rates for heart failure, utilization of Medicare services, Medicare costs, patient adherence to the prescribed medical regimen, and functional status. Thus, the demonstration will assess the impact of this technology on a range of clinically and policy relevant heart failure outcomes.
Status: Four hundred and forty Medicare beneficiaries, recently hospitalized for management of new onset heart failure or an acute exacerbation of previously existing heart failure, were enrolled at three geographical sites of different character: rural, (Billings Montana); small Metropolitan Statistical Area, (Louisville, Kentucky); and major Metropolitan Statistical Area, (Philadelphia, Pennsylvania).

01-264 Innovations in Health Care
Project Officer: Dennis Nugent
Period: September 2001–September 2002
Awardee: Duke University, Health System
Funding: $775,833

Description: This is a three-phase study. First, it will develop policy case studies in strategic health planning designed to highlight the importance of integrative disease management and strategic health planning for patients with three complex and chronic diseases (congestive heart failure, diabetes, and depression). A policy case study on the management of obstetric care at them time of delivery will also be conducted. The second will summarize the evidence and develop an evidence-based approach to patient-specific strategic health planning that services to link risks and behaviors to action items unique for each patient independent of any particular disease. The plans will incorporate a broad-based integrative approach including strategies regarding nutrition, exercise, stress management, and social support. The project will then implement strategic health planning in a defined patient cohort. Finally, the project will be a cost and policy analysis of secondary prevention for patients with coronary artery disease. The objectives here will be to maximize the appropriate use of secondary prevention for this disease in Medicare patients; measure the financial impact on hospitals, providers, and patients of improving secondary prevention; and examine the effectiveness of strategies to improve adherence of physicians and patients to secondary prevention.
Status: The project is newly underway.

01-277 Study on Medicare Coverage of Routine Thyroid Screening
Project Officer: Katharine Pirotte
Period: September 2001–March 2003
Awardee: National Academy of Sciences, Institute of Medicine
Funding: $450,000
Description: This is a study on the addition of coverage of routine thyroid screening using a thyroid stimulating hormone test as a preventive benefit under Medicare. This is a mandated study [section 123 of the Benefits Improvement and Protection Act of 2000]. The mandate also requires that this involve the Academy's United States Preventive Services Task Force. The study is to consider the short-term and long-term benefits and the cost to the Medicare program of such an additional benefit.
Status: The project is newly underway.

01-257 National Initiative for a Long-term Care Workforce of Paraprofessionals
Project Officer: Karen Tritz
Period: July 2001–December 2002
Awardee: Office of the Assistant Secretary for Planning and Evaluation
Funding: $300,000
Description: This provides support for a project to develop a national initiative for a qualified, committed and stable long-term care workforce of paraprofessionals (home health aides, nurse assistants, personal care assistants). This initiative will contain four elements: State and local innovation grants, an applied research program, an awareness and education campaign, and an information clearinghouse on workforce innovation.
Status: This is a newly established project in its startup phase.

01-259 Evidence Report on Routine Thyroid Screening
Project Officer: Katharine Pirotte
Period: September 2001–June 2002
Funding: $50,000
Awardee: Agency for Healthcare Research and Quality
Description: This project is an evidence report on routine thyroid screening using the thyroid stimulating hormone test (TSH). This report is to be developed by the Evidence-based Practice Center. Medicare cannot pay for preventive services unless such has been added by law. We are interested in expanding the current preventive services offered by Medicare. The Benefits Improvement and Protection Act requires that we obtain a study from the National Academy of Sciences and the U.S. Preventive Services Task Force on the addition of coverage for routine thyroid screening using the TSH test. This study is to consider the short and long term benefits as well as the costs of such an additional preventive benefit. This project will involve 1) research and systematic review of clinical evidence of this screening, including its efficiency and effectiveness as it applies to the Medicare population, 2) the identification of sub-populations at greatest risk, 3) an assessment of potential benefits of routine screening, and 4) a syntheses of the evidence to provide the foundation for the development of evidence-based recommendations.
Status: This project is in the early stages.

94-074 Design and Implementation of Medicare Home Health Quality Assurance Demonstration
Project Officer: Armen Thoumaian
Period: September 1994–December 2003
Awardee: Center for Health Policy Research, University of Colorado
Funding: $5,185,699
Description: The Medicare Home Health Quality Assurance Demonstration has developed and tested an approach to develop outcome-oriented quality assurance techniques and promote continuous quality improvement in home health agencies (HHA). The goal of the demonstration was to determine the feasibility of a methodology for a national approach for outcome-based quality improvement (OBQI). Outcome measures were computed using the Outcomes and Assessment Information Set (OASIS). Under the demonstration, staff of 54 regionally dispersed HHAs completed the OASIS data collection instrument for each patient at the start of care and at 60-day intervals (up to and including discharge). CHSR then conducted three rounds of data analysis and outcome report generation, each based on 12 months of data. Risk adjusted reports are produced for 41 specific patient quality outcomes for all adult patients. These reports are provided to the participating HHAs and are used to determine which outcomes need improvement, thereby providing a focus for agency staff to target problematic care. The demonstration resulted in significant improvement in 80 percent of agency-specific outcome targets, with a yearly improvement in re-hospitalization rates across all agencies.
Status: Fifty-four agencies in 26 States were phased into the demonstration beginning in January 1996. In January 1997, the demonstration agencies received their first outcome reports and developed plans of action to improve care for two patient outcomes during 1997. Agencies received their second annual reports in May 1998, which contained baseline comparisons from 1997, and received their third and final reports in May 1999. A final report has been completed and is available. Funding was increased to a total of $5,185,000 and the project was extended 3 years to December 2003.

98-257 Development and Validation of Measures and Indicators of the Quality Appropriateness of Services Rendered in Post-Acute and Long Term Care Settings
Project Officer: Yael Harris
Period: September 1998–September 2003
Awardee: Abt Associates
Funding: $5,247,965
Description: This project is developing and validating a comprehensive set of performance measures and indicators of quality for institutional post-acute and long-term care settings. The post-acute settings involved include skilled nursing facility short-stay units, inpatient rehabilitation facilities (which include hospital-based rehabilitation units), and long-term care hospitals. Performance measures will be standardized across provider types, in order to allow necessary comparisons to be made about outcomes of care. Performance measures may also be used within CMS' regulatory quality monitoring programs to inform quality improvement activities, to provide information to consumers, and to provide information to payers of health care for use in evaluating the quality and care delivery. The use of quality measures and indicators, such as those to be developed under this project, will allow CMS to determine objectively the value of the care it purchases by providing a valid measurement of the care furnished by Medicare-participating providers.

Status: Based on the comments and feedback received, a final set of nine new long term care QIs and eight post-acute QIs were developed. The team is currently involved in the validation of these measures as well as preparing 11 of these measures (9 long term care indicators and 4 post acute indicators) for Public reporting in 6 pilot States beginning in April 2002. A set of measures is expected to be posted on Medicare.gov for all nursing homes in the U.S. beginning October 2002.

HOME HEALTH OUTCOME BASED QUALITY IMPROVEMENT SYSTEM PILOT DEMONSTRATION - HH OBQI SYSTEM

Description: The goal of this pilot project is to explore the feasibility of establishing a national home health outcome based quality improvement (OBQI) system. Quality Improvement Organizations (QIOs, formerly known as Peer Review Organizations or PROs) work with home health agencies (HHAs) to implement quality improvement programs and provide consultation to CMS, its contractors, and State agencies. The QIOs provide a supportive role to HHAs in their endeavors to comply with Medicare Conditions of Participation, assist the State agencies in related monitoring and enforcement efforts, assist CMS and Regional Home Health Intermediaries (RHHIs) in home health program integrity assessment, and prepare summary information about the Nation's home health care. Major objectives include: develop training materials for the pilot QIOs and HHAs about the Outcome and Assessment Information Set (OASIS), OASIS outcome reports, OASIS based quality improvement programs; assist the other pilot PROs to provide OBQI training and/or consultation to the HHAs in their State, to State agencies, and CMS; provide regular assessments of local, regional and national home health services, create a clearing house to distribute information about best practices in home health; develop materials for Medicare beneficiaries to facilitate proper interpretation of home health outcome reports; and perform special studies to assist in CMS quality improvement, program integrity and medical review efforts in HHAs. Although State agencies will be responsible for generating State aggregate information using agency-specific reports, a mechanism has not been developed to provide support to the HHAs to develop and manage quality improvement programs.

Status: The QIOs assist the State agencies in related monitoring and enforcement, work with home health agencies (HHAs) to implement quality improvement programs, and provide consultation to CMS, its contractors, and State agencies.

01-211 Integrated Chronic Disease Quality Performance Measurement at the Physician Level

Project Officer: Barbara Fleming
Period: September 2001–March 2004
Awardee: C.N.A. Corporation
Funding: $499,999

Description: This project is to assist CMS in exploration of the issues important to physician level quality of care scoring in chronic disease and prevention. The project will help to define quality of care for chronic disease using existing performance measures and will use existing data to begin to model these concepts. Performance measurement supports CMS program management and policy development purposes, such as quality improvement in the QIO program, demonstration of accountability, and value-based purchasing. Several of our projects have attempted to integrate broader chronic disease- based thinking into their measurement structure (i.e., the Diabetes Quality Improvement Project or DQIP, the Study of Clinically Relevant Indicators of Pharmacologic Therapy or SCRIPT, and the Ambulatory

Care Quality Improvement Program or ACQIP). The ACQIP data will be the primary vehicle for the initial work. The second phase applies knowledge gained in diabetes care quality measurement to develop a framework and model for composite quality of care scoring for chronic disease.
Status: This project is in the startup phase.

01-118 Improved Protocols for Home Health Agency Assessment in the Survey Process
Project Officer: Tracey Mummert
Period: September 2001–March 2004
Awardee: Center for Health Policy Research, University of Colorado
Funding: $797,000
Description: The purpose of this project is to assess the existing home health agency (HHA) survey process and make recommendations for improvements. Improvements include patient-focused, outcome-oriented, data-driven approaches that are effective and efficient in assessing, monitoring and evaluating the quality of care delivered by an HHA. The project will also evaluate the effectiveness of current survey forms, develop new survey forms, as applicable, and make recommendations for prioritizing onsite survey time. The assessment will focus on the Outcome and Assessment Information Set (OASIS), designed for the purpose of enabling the rigorous and systematic measurement of patient home health care outcomes, with appropriate adjustment for patient risk factors affecting those outcomes; and the Online Survey Certification and Reporting System (OSCAR).
Status: The period of performance was extended to June 2004. To date, several States have volunteered to participate in the testing of the new survey protocols.

01-268 Ultrasound Screening for Abdominal Aortic Aneurysms
Project Officer: William Saunders
Period: September 2001–September 2002
Awardee: Dartmouth University
Funding: $500,000
Description: The objectives of this project are to determine the feasibility and benefit of ultrasound screening to detect abdominal aortic aneurysm in Medicare beneficiaries. It will determine the prevalence of such aneurysms in the screened population, evaluate the cost of developing and maintaining an ultrasound screening program to detect these aneurysms and determine the cost-effectiveness of screening Medicare patients.
Status: This award was directed by the FY2001 Appropriation bill, PL 106-554.

01-170 Development of Quality Indicators for Inpatient Rehabilitation Facilities
Project Officer: Lisa Hines
Period: September 2001–September 2003
Awardee: Research Triangle Institute, (NC)
Funding: $1,420,000
Description: The purpose of this project is to support developing and defining measures to monitor the quality of care and services provided to Medicare beneficiaries receiving care in inpatient rehabilitation facilities. It will identify the elements integral to assessing quality of care in rehabilitative services and developing a set of measures for use by States.

Status: The period of performance was extended to June 2004. To date, several States have volunteered to participate in the testing of the new survey protocols.

01-289 Northern New England Vascular Surgery Quality Improvement Initiative - II
Project Officer: Sheila Roman
Period: September 2001–September 2002
Awardee: Dartmouth University
Funding: $500,000
Description: The goal of this study is to improve the care of patients undergoing vascular surgery. Data will be collected regarding indications, comorbidities, operative details and outcomes for vascular surgery, including abdominal aortic aneurysm repair. A risk adjuster model will be developed. The study will use a cooperative clinical data registry, benchmarking visits by clinicians, comparative process analysis, and continuous quality improvement to improve outcomes and reduce variation in care delivery.
Status: This award was directed by the FY2001 Appropriation bill, PL 106-554.

01-221 Northern New England Vascular Surgery Quality Improvement Initiative - I
Project Officer: Beth Kosiak
Period: September 2001–September 2003
Awardee: Trustees of Dartmouth College, Office of Grants and Contracts
Funding: $262,000
Description: The goal of this project is to improve the care of patients undergoing vascular surgery in Maine, New Hampshire and Vermont. A data registry will be used to collect detailed clinical information on patient care. A risk-adjustment model will be developed to analyze the outcomes of care. Outcomes reporting and benchmarking visits will be used to improve outcomes and reduce variations in care delivery.
Status: This project is in the startup phase.

02-056 Examining Long-Term Care Episodes and Care History for Medicare Beneficiaries
Project Officer: William Buczko
Period: September 2002–September 2005
Awardee: Urban Institute
Funding: $649,958
Description: This project studies longitudinal patterns of care of elderly beneficiaries with likely long-term care needs and the progress of groups of beneficiaries with similar health/functional status who remain in the community or who move from the community to institutional settings, as well as within institutional settings. It will develop a research model and conduct studies based on this model to assess the progress of beneficiaries with similar medical conditions, functional status, and long-term care needs through the health care delivery system. It will address key factors influencing the delivery of care such as insurance coverage, types of services used, processes leading to institutionalization, and costs of care.

98-276 Healthy Aging/Smoking Cessation
Project Officer: James Coan
Period: October 1998–September 2004
Awardee: RAND Corporation
Funding: $200,000
Description: This demonstration will test smoking cessation as a Medicare benefit, based on RAND's Healthy Aging Project evidence report on smoking cessation and the Public Health Service clinical guideline on treating tobacco use and dependence. The demonstration will compare the impact of offering three different types of benefits for smoking cessation services on "quit" rates. The benefit options are: 1) reimbursement for provider counseling only; 2) reimbursement for provider counseling, in addition to FDA-approved prescription or nicotine replacement therapy; and 3) telephone counseling quit-line and reimbursement for nicotine replacement therapy; and 4) usual care (smoking cessation information). States participating in the demonstration are Alabama, Florida, Missouri, Ohio, Oklahoma, Nebraska, and Wyoming.
Status: Legislation is required to add a smoking cessation benefit in Medicare. The Office of Management and Budget (OMB) agreed to the waiver which permits these demonstrations to operate in January 2001.

01-217 Healthy Aging/Smoking Cessation
Project Officer: James Coan
Period: August 2001–February 2002
Awardee: Olgivy, Seniors Research Group
Funding: $253,275
Description: This demonstration is a part of the Healthy Aging Project and is intended to test potential interventions for smoking cessation that may be offered as a Medicare covered benefit to beneficiaries who smoke. The following variations in a smoking cessation benefit will be tested: 1) provider counseling reimbursement only, 2) provider counseling reimbursement with bupropion or nicotine replacement pharmacotherapy coverage, 3) Quitline and nicotine replacement pharmacotherapy coverage, and 4) usual care. The specific goals of the Medicare Stop Smoking Program are to evaluate the effectiveness, feasibility, and cost of the smoking cessation benefit strategies in seven States and to make inferences that are generalizable to the Medicare program.
Status: The States participating in the demonstration are Alabama, Florida, Missouri, Nebraska, Ohio, Oklahoma, and Wyoming.

96-050 Influenza and Pneumococcal Analytic Reports
Project Officer: Lawrence LaVoie
Period: September 1996–January 2002
Awardee: CHD Research Associates
Funding: $698,924
Description: This project develops a research data base using CMS Medicare claims data to study the epidemiology of influenza (flu) and pneumococcal vaccination (PPV). One goal is to promote vaccinations by health-care providers, and to support coverage for Medicare beneficiaries. For example, Medicare claims records for PPV are extracted and

merged to create a beneficiary-level PPV research file used to generate annual and cumulative immunization rates. Using both the PPV file and flu immunization data file, a series of national and State-specific statistics are produced. Medicare utilization and enrollment data are linked with the PPV and flu files data to analyze immunization rates of high-risk beneficiaries.
Status: A PPV research file update with 2000 Medicare claims has been completed. National and State-specific statistics, based on analysis of 1999 Medicare claims, have been published in tables and reports and posted on CMS' web site.

96-219 Medicare State Health Profile
Project Officer: Paul Elstein, Benedicta Abel-Steinberg
Period: September 1996–April 2002
Awardee: RAND Corporation
Funding: $2,146,988
Description: This project analyzes claims data at the State level and enhances data with additional diagnosis-specific analyses and analyses of inpatient encounter data from Medicare+Choice organizations, focusing on four of clinical priority areas (acute myocardial infarction (AMI), heart failure, diabetes, breast cancer, pneumonia, and stroke/ transient ischemic attack). CMS contracts with Quality Improvement Organizations (QIO, formerly peer review organizations) in each of the 50 States, and in the District of Columbia, Puerto Rico, and the Virgin Islands. QIOs are focusing on quality outcomes through the Health Care Quality Improvement Program (HCQIP). The outcome measures for the clinical areas include mortality and re-admissions, and data sources include claims, medical records, and surveys.
Status: Analyses are available from the CMS web site.

00-120 Implementation of Quality Improvement Organization 6th Scope of Work Pneumococcal Pneumonia and Influenza Immunization Remeasurement Survey
Project Officer: Susan Arday
Period: September 2000–November 2002
Awardee: Abt Associates
Funding: $1,542,230
Description: This project specifically implements the Pneumococcal Pneumonia and Influenza Immunization Remeasurement Survey. The goal is to assess the utilization of influenza and pneumococcal vaccines among Medicare beneficiaries, and to evaluate the vaccine promotion work performed by Quality Improvement Organizations (QIO, formerly Peer Review Organizations) under their Medicare sixth Scope of Work. The survey is administered to a sample of Medicare beneficiaries randomly selected from each of 50 States plus the District of Columbia and Puerto Rico, and will produce the attendant State-specific rates.
Status: There are two separate, sequential rounds of data collection. All data collection and delivery for the first round was completed by June 2001. The second round of the survey data collection was completed June 2002.

01-220 Heart Failure Home Care
Project Officer: John Pilotte
Period: September 2001–September 2004
Awardee: University of Pittsburgh, Office of Research
Funding: $1,847,941
Description: This project seeks to use integrated nursing services and technology to implement daily monitoring of congestive heart failure patients in under-served populations in accordance with established clinical guidelines. The demonstration tests the clinical and economic effectiveness of the Alere Day Link Home Monitoring Device in Medicare beneficiaries from under-served population groups receiving care in community-based practices who are diagnosed with congestive heart failure and who have had a hospitalization within the last 6 months. The primary hypothesis is that the addition of this device to standard management of heart failure will reduce 6-month heart failure hospitalization rates, cardiovascular death, and decrease length of hospital stay for heart failure.
Status: This newly initiated project is in the startup phase.

00-053 Medicare Lifestyle Modification Program Demonstration Evaluation
Project Officer: Armen Thoumaian
Period: September 2000–August 2005
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
Funding: $1,995,144
Description: This project evaluates the health outcomes and cost effectiveness of the Medicare Lifestyle Modification Program Demonstration for Medicare beneficiaries with coronary artery disease (CAD). The demonstration tests the feasibility and cost effectiveness of providing payment for cardiovascular lifestyle modification program services to Medicare beneficiaries. The goal of the evaluation is to provide an assessment of the health benefit and cost-effectiveness of treatment for Medicare beneficiaries with CAD who enroll in the 12-month cardiovascular lifestyle modification programs at the demonstration sites. The evaluation of the demonstration assesses the overall performance of the demonstration sites, including the quality of health care delivery over the course of the demonstration period; and the use of systems for administration, claims processing and payment, and the routine monitoring of quality of care.
Status: In September, 2001, the evaluation was expanded to include a longer followup period of treatment and control patients and to include a critical review of literature. Preparations are being made to begin efforts to find Medicare beneficiaries that can be matched to those receiving treatment and followed as controls. We are awaiting final OMB approval of the beneficiary and provider survey instruments. The evaluation team has completed initial site visits and submitted a site visit report with recommendations.

99-136 Medicare Lifestyle Modification Program Demonstration Continuous Quality Monitoring
Project Officer: Mary Pratt
Period: July 1999–September 2003
Awardee: Delmarva Foundation for Medical Care
Funding: $639,215
Description: This project provides the quality monitoring for a 4-year payment demonstration designed to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. The demonstration is being implemented at participating sites licensed by the Dr. Dean Ornish Program for Reversing Heart Disease®, and is being expanded to include facilities licensed to provide the Cardiac Wellness Expanded Program of Dr. Herbert Benson and the Mind Body Medical Institute. Sites under each model will be able to enroll up to 1800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. Claims processing and payment are managed through the Demonstrations Management Branch in the Office of Financial Management. This project provides continuous quality monitoring of the demonstration sites to help assure the health and safety of the participating Medicare patients.
Status: The period for the demonstrations commenced on October 1, 1999. On November 28, 2000, the enrollment criteria were amended to include patients with less severe cardiovascular disease. In accordance with Public Law 106-554, the Consolidated Appropriations Act of 2001, steps have been completed to incorporate the lifestyle program of the Mind/Body Medical Institute (M/BMI) into the demonstration. The same law provided a mandate for a 4-year treatment period beginning November 13, 2000. DelMarVa continues to provide the quality monitoring for the demonstrations, as modified.

MEDICARE LIFESTYLE MODIFICATION PROGRAM DEMONSTRATION - PREVENTIVE MEDICINE RESEARCH INSTITUTE
Description: The Medicare Lifestyle Modification Program Demonstration is a 4-year payment project implemented to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. The demonstration is being implemented at participating sites licensed by the Dr. Dean Ornish Program for Reversing Heart Disease®. Sites will be able to enroll up to 1800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites will receive 80 percent of a total negotiated fixed payment amount for a 12-month program. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Demonstrations Management Branch in the Office of Financial Management.
Status: On November 28, 2000, the enrollment criteria were amended to include patients with less severe cardiovascular disease. In accordance with Public Law 106-554, the Consolidated Appropriations Act of 2001, steps have been completed to incorporate a second lifestyle program operated by the Mind/Body Medical Institute (M/BMI) into the overall demonstration.

MEDICARE LIFESTYLE MODIFICATION PROGRAM DEMONSTRATION - MIND/BODY MEDICAL INSTITUTE
Description: The Medicare Lifestyle Modification Program Demonstration is a 4-year payment project implemented to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. The demonstration is being implemented at participating facilities licensed to provide the Cardiac

Wellness Expanded Program of Dr. Herbert Benson and the Mind Body Medical Institute. Sites under this model will be able to enroll up to 1800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites will receive 80 percent of a total negotiated fixed payment amount for a 12-month program. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Demonstrations Management Branch in the Office of Financial Management.
Status: On November 28, 2000, the enrollment criteria were amended to include patients with less severe cardiovascular disease. In accordance with Public Law 106-554, the Consolidated Appropriations Act of 2001, steps have been completed to incorporate this lifestyle program of the Mind/Body Medical Institute (M/BMI) into the overall demonstration.

99-094 Improving Managed Care Outcomes Using Medicare Health Outcomes Survey Data
Project Officer: Sonya Bowen
Period: May 2000–October 2002
Awardee: Health Services Advisory Group
Funding: $1,529,185
Description: This project provides data cleaning, scoring, and performance profiling of (HOS) data collection. It trains managed care plans and Quality Improvement Organizations (QIO, formerly Peer Review Organizations) in the use of functional status measures and best practices for improving care. It also provides technical assistance for QIOs and plan interventions designed to improve functional status. Fiscal year 2002 will mark the release of HOS functional change scores for cohort 1 to plans, QIOs, and the public.
Status: The cohort 1 performance measurement reports were released to QIOs and plans in December 2001. A public release of data is expected in February 2002. Two-year functional status change scores and performance profiles for each plan have been developed from a merged cohort 1 baseline and remeasurement data set. Round 4 data submission, cleaning, and analysis from the 2001 HOS field administration will be completed in early 2002. Round 5 will be completed in late 2002. A national Quality Improvement System for Managed Care (QISMIC) pilot project, using HOS data to target beneficiaries at high risk for depression, continues. A conference is planned for the fall in Baltimore.

00-075 Efficacy of a Culturally Sensitive Health Promotion Program To Improve Exercise and Dietary Behaviors in African American Elders with Hypertension
Project Officer: Richard Bragg
Period: September 2000–September 2002
Awardee: Southern University and A&M College, School of Nursing
Funding: $205,142
Description: The project is to test the efficacy of a culturally sensitive health promotion program that seeks to improve exercise and diet, two behaviors important in controlling hypertension in African American elders with hypertension. The project will compare the impact of outcomes of: knowledge, efficacy expectations and outcomes (beliefs about performing exercise and dietary behaviors), and change on exercise and dietary behaviors of elders who participate in one of two versions of a health promotion program. The first year will be conducted in Baton Rouge, Louisiana and the second year in

Jackson, Mississippi, under the coordination of the two participating universities. The intervention will be conducted at public housing complexes and involve resident coordinators who would serve as liaisons between participants and researchers.

Status: Data is collected at baseline and remeasured at 3 and 6 months on nine variables. This project, which was awarded under CMS' grant program for Historically Black Colleges and Universities, is in progress.

99-116 Medicare Current Beneficiary Survey - II
Project Officer: Frank Eppig
Period: September 1999–September 2004
Awardee: Westat Corporation
Funding: $12,925,094
Description: The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a representative sample of the Medicare population designed to aid CMS' administration, monitoring, and evaluation of the Medicare program. The survey is focused on health care use, cost, and sources of payment. Additionally, the MCBS is the only source of multidimensional person-based information about the characteristics of the Medicare population and their access to and satisfaction with Medicare services.
Status: The MCBS has been in the field continuously since the fall of 1991. It is currently in its 29th round of interviewing. To date, public use data files are available for 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, and 1999.

01-216 Analysis of Medicare Current Beneficiary Survey (MCBS) Data: Phase III
Project Officer: Sherry Terrell
Period: May 2001–May 2003
Awardee: Research Triangle Institute, (NC)
Funding: $217,132
Description: This project evaluates CMS' success in providing information to each Medicare beneficiary about the Medicare program and promoting the beneficiary's informed choice. Information provided covers benefits, beneficiary liability, premiums, supplemental benefits, a list of plans in the service area and comparison of plan options, quality and performance. This task order analyzes Medicare beneficiary baseline knowledge data, which have been most recently collected through the Medicare Current Beneficiary Survey (MCBS). Analysis of the MCBS baseline data supports monitoring, reporting, accountability and evaluation activities necessary to determine whether the new CMS programs are working as intended.
Status: These analyses continue and build on the prior analyses of the CY 1995-1999 MCBS data including Round 23 (knowledge supplement) and Round 24 (beneficiary need supplement) under previous task order 500-95-0061/04.

CMSO's Grants, Research Projects, and Demonstrations for 2001 and 2002

AIDS Healthcare Foundation in Los Angeles
Project No.: 15-P91118/9-02 and 15-P-91118/9-03
Period: 4/15/01 - 9/30/01 and 9/30/02 - 3/15/03
Funding: $1,700,000 + $2,000,000
Award: Grant
Principal Investigator: Michael Weinstein
Awardee: AIDS Healthcare Foundation
CMS Project Officer: Jean Close, x62804
Description:
Grants were used to fund patient care in the Success Through Anti-Retroviral Therapy (START) Program. START is the Foundation's short-term residential treatment facility program that seeks to improve the compliance of people living with HIV and AIDS with the complicated medication regimen necessary for improving their health.

Nursing Facility Transitions Grants--Research and Evaluation
Project No.: Various, 17 Grants awarded (FY 01); 16 Grants awarded (FY 02)
Period: 9/28/01 – 9/27/04 and 9/30/02 - 9/29/05
Funding: FY 01 - $9,028,888 (NFT-SP) grants and $2,058,178 (NFT-ILP) grants,
FY 02 - $6,735,216 (NFT-SP) grants $1,807,500 (NFT-ILP) Grants
Award: Grants
Principal Investigator: various
Awardees: States and Independent Living Centers.
CMS Project Officer: Mary Guy, x62772
Description: The purpose of the "Nursing Facility Transitions" grants is to help eligible individuals make the transition from nursing facilities to the community. NFT Grants are of two types—State Program (SP) Grants supporting SP initiatives and Independent Living Partnership (ILP) Grants. State Program grants are being can be used for a wide range of activities, e.g., a State may wish to use State Program grant funds to develop strategies for linking individuals with disabilities to Section 8 rental housing vouchers or developing other coordinated housing strategies. The Independent Living Partnership grants are designed to promote partnerships between States and selected Independent Living Centers (ILC's) to support the transition of individuals from nursing facilities to their communities. Note: Previous Nursing Home Transition Grants were awarded by CMS in 1998, 1999, and 2000.

Real Choice Systems Change
Project No.: Various 25 Grants awarded (FY 01); 25 Grants awarded (FY 02) plus 5 supplemental grants to FY 01 grantees.
Period: 9/28/01 – 9/27/04 and 9/30/02 -9/29/05
Funding: $40,819,854 and $33,804,143 + $1,800,000 (5 supplemental awards to FY 01 Grantees)
Award: Grants
Principal Investigator: Various
Awardee: States
CMS Project Officer: Mary Fran Deutsch x60119
Description: The purpose of "Real Choice Systems Change" grants is to assist States in designing and implementing effective and enduring improvements in community long term support systems. These grants are intended to foster the systemic changes to enable children and adults of any age who have a disability or long term illness to:

- Live in the most integrated community setting appropriate to their individual support requirements and their preferences;
- Exercise meaningful choices about their living environments, the providers of services they receive, the types of supports they use and the manner by which services are provided; and
- Obtain quality services in a manner as consistent as possible with their community living preferences and priorities.

Demo. To Establish Investigative Unit (Equip for Equality)
Project No.: 18-P-91676/5-01
Period: 10/1/01 – 9/30/06
Funding: $150,000 + $771,000
Award: Grant
Principal Investigator: Deborah M. Kennedy
Awardee: Equip for Equality
CMS Project Officer: Mary Clarkson, x65918
Description:
Equip for Equality is a private, not-for-profit legal advocacy organization designated by Governor Thompson in 1985 to implement the federally mandated Protection and Advocacy system in Illinois. Equip for Equality has broad federal and state authority, including the right to conduct investigations of abuse and neglect and access to investigative reports prepared by state departments. This demonstration project is to examine deaths or other serious allegations of abuse and neglect of people with disabilities at facilities in Illinois, and to enhance existing state systems charged with investigating serious incidence of abuse and neglect of individuals with disabilities. The project will examine deaths or other serious allegations of abuse or neglect. The grantee will prepare and release reports to the public with recommendations to prevent such incidents in the future, and follow up with facilities and appropriate government agencies to ensure that the recommendations are implemented.

Children's Hospice Care Demonstration
Project No.: 95-P-91371/3 and 95-P-91718/3
Period: 5/15/01 – 5/14/02 and 5/1/02 – 5/31/03
Funding: $855,000 + $900,000
Award: Grant
Principal Investigator: Ann Armstrong-Dailey
Awardee: Children's Hospice International
CMS Project Officer: Melissa Harris, x63397
Description: Children's Hospice International has developed the CHI Program for All-Inclusive Care for Children (CHI PACC) model to provide enhanced services to children with life-threatening conditions and their families. Grant monies were used to provide start-up funding for states/providers selected on a competitive basis to develop the infrastructure necessary implement a CHI PACC program.

L.A. Care Health Plan
Project No.: 18-P-91675/9-01
Period: 09/30/01 – 09/29/02
Funding: $251,576
Award: Grant
Principal Investigator: Pamme Lyons
Awardee: L.A. Care Health Plan
CMS Project Officer: Nancy Olsen, x60617
Description:
This is a technology assessment and improvement project among traditional and safety net providers in Los Angeles County. The primary goal is to increase electronic clinical and business practices through Electronic Data Interchange. Within the health care delivery system, information technology is considered a prerequisite to integrated high quality care. The shift to Medicaid managed care through the country has intensified the demand for information systems that can generate the data necessary to track eligibility/enrollment, measure quality, monitor costs, submit claims, obtain authorizations and more. Survival for the traditional and safety net provider in the current health care techno-culture requires an understanding and investment information technology. Traditional and safety net providers dedicated to serving low-income communities are not able to invest in the improvement of information technology due to limited resources.

Shelby County Regional Medical Center
Project No.: 18-C-91171/4-01
Period: 09/30/01 – 09/29/02
Funding: $646,000
Award: Grant
Principal Investigator: Bruce Steinhauer
Awardee: Regional Medical Center at Memphis
CMS Project Officer: Nancy Olsen, x60617
Description:
Shelby County's 2001 grant proposal explains that the funds from this grant will enable the Regional Medical Center at Memphis (The MED) to implement a practice management system that is integrated or interfaced with an electronic medical record system (EMR). The funds will also be used to develop a quality of care reporting system for chronic disease care based on treatment guidelines.

This grant will also allow the *Health Loop* to expand reporting to create a comprehensive prevention report card. Development will occur while transitioning from practice management data to electronic clinical data. Specifically, funds will be used over a 12-month period for training staff, site visits, developing and implementing treatment guidelines for selected chronic diagnoses, obtaining hardware, software, license and maintenance agreements required to operate the information system in the Shelby County Health Care Network—*The Health Loop*.

Medigap Enforcement Demonstration Grants
Project No.: Multiple
Period: Between 9/02 – 6/04
Funding: $249,025 + $255,876
Award: Grant
Principal Investigator: Multiple
Awardee:
CMS Project Officer: Marcia Marshall, x66674
Description: this project was designed to test strategies for gathering data on regulatory violations in the Medicare supplement insurance (Medigap) markets. Authority for regulation of Medigap insurance issuers is split between states and CMS. Anecdotal reports of market violations encouraged PHIG to work with specific states to test various concepts of how to generate a clearer picture of how well the markets were serving beneficiaries in terms of guaranteed access to Medigap insurance policies. Over 2 years, 11 State Health Insurance Assistance Programs (SHIPS) received grants to investigate compliance problems in their own markets. Some projects are still in process.

Instrumentation & Performance Measurement for Quality Under HCBWs Self Directed Measures

Project No.: Contract# 500-96-0006, Task Order #2
Period: 9/30/00 - 9/29/04
Funding: $120,000 + $480,116
Award: Task Order, Modification
Principal Investigator: Brian Burwell
Awardee: Medstat
CMS Project Officer: Suzie Bosstick, x61301
Description:
This initiative serves to further develop quality strategies for individual and family-directed home and community-based waiver programs and will coordinate the delivery of the self-directed and pharmacy templates to the states. Accomplishments include:

- Identification of Key Components – The contractor has researched and reviewed available literature on self-directed programs throughout the nation, obtained comments from various experts in the disability field, and drafted a group of system functions. To ensure the products are well grounded, between 3-5 site visits to relatively well established self-directed programs are taking place. Based on the site visits, conversations with experts and CMS input, the measures will continue to be refined, and material developed for states to use as resources as they use the performance measures.
- Convening of an Advisory Work Group – The contractor continues to routinely convene an Advisory Work Group composed of experts in self-directed representatives from States which support self-direction and CMSO staff. The group contines to provide ongoing feedback and consensus building around performance measures and serves as the sounding board for instrument refinements.
- Performance Measures – The contractor continues to develop performance measures and indicators of the key functions that will assist states and CMS to assess self-directed delivery model programs. The tool will be used to enable states to assess the quality of their waiver programs and would give CMS staff a method to provide technical assistance to states based on effective practices and desired outcomes for operating a successful self-directed waiver.

National Evaluation of Quality in the Medicaid HCBS Waiver Program
Project No.: Contract# 500-96-0006, Task Order #2
Period: 9/30/01 - 9/29/04
Funding: $950,000
Award: Task Order, Modification
Principal Investigator: Brian Burwell
Awardee: Medstat
CMS Project Officer: Suzie Bosstick, x61301
Description:
This task order assists in the development of a quality framework for home and community-based waiver programs and facilitates the provision of technical assistance. The specific purpose of the task order is to engage the services of a Contractor who has demonstrated ability to engage and supervise highly skilled, qualified and trained professionals to work with CMS/CMSO. The following tasks and products have been completed:

- Developed a national survey tool to establish an inventory of quality improvement strategies utilized by all fifty States in the administration of their HCBS waiver program for the aged/disabled and for persons with mental retardation/developmental disabilities.
- Conducted on-site visits with States to review their quality improvement strategies.
- Developed a draft quality improvement framework to guide future CMSO quality efforts.
- Identified promising practices for effectively working quality improvement systems in States
- Identified State specific opportunities for improvement, and identify potential improvements in CMSO's quality monitoring efforts.

Development of Behavioral Health Performance Measure(s) for Children
Project No.: 752-2-416001
Period: 9/17/01 – 3/17/03
Funding: $190,000
Award: Sole Source
Principal Investigator: Christina Bethell, PhD
Awardee: The Foundation for Accountability (FACCT)
CMS Project Officer: Fran Crystal, x61195/Susie Bosstick, x61301
Description:
The purpose of this contract was to refine and test a previously designed measure of health care quality that could be used to assess the effectiveness of Medicaid MCOs, PCCM Programs and Fee-for-Service in delivering appropriate illness care to young children with a variety of common childhood illnesses. FACCT previously developed a model (the ACSH mode) for assessing the overall effectiveness of health care service delivery.

FACCT developed a prototype composite ASCH specifically to measure the quality of care for young children with acute illnesses. As a composite model it addresses care for

multiple common acute conditions where hospitalization for these conditions is not expected except for cases where early and/or appropriate outpatient intervention does not take place. The prototype complements disease and process-specific measures that may mask overall system performance shortfalls or successes.

FACCT is using this prototype model to develop and test a measure or measures for use by state Medicaid agencies in their MCO, PCCM and FFS programs. If successful in the testing, it is hoped this measure will become part of a set of measures for state Medicaid and S-CHIP programs to assess the quality of care.

FACCT is refining its model in consultation with an expert panel (approved by CMS) consisting of individuals with expertise in pediatric clinical care and quality measurement. In Phase I a detailed work plan was developed and the expert panel was recruited, key informant interviews were held, and a review was performed of the literature to be included in the Advisor Group meeting materials. In Phase II FACCT developed the specifications for testing the measures by collecting from various sources data on potential strengths and weaknesses of the current prototype measure developed previously by FACCT. The first Advisory Group call took place in July 2002 and the expert panel was convened in August 2002.

In Phase III FACCT began testing of the reliability and validity of the resulting measure(s) in a sampling of state Medicaid programs and present the findings to CMS.

In Phase IV FACCT will develop a final report that includes an assessment of the feasibility of use of performance measures in Medicaid MCO, PCCM and FFS programs and, in consultation with CMS, FACCT will develop a dissemination strategy.

Collection, Analysis, & Dissemination of Best Practices, State Planning/Infrastructure
Project No.: 500-96-0006, Task Order #2
Period: 9/30/00 - 9/29/03 and new contract 9/30/03 - 9/29/04
Funding: $550,000 + $450,000
Award: Task Order, Modification
Principal Investigator: Brian Burwell
Awardee: MEDSTAT
CMS Project Officer: Alissa Deboy, x66041
Description:
CMS, under a partnership role with states in the administration of the Medicaid program, is providing technical assistance to states to improve home and community-based long-term support services. As part of this effort, CMS has contracted with MEDSTAT to identify and highlight promising practice within states that promote community living for persons with disabilities

The goal of this contract is to provide useful information for states that are in the midst of designing improvements to or reforming their long term care systems. Recent trends highlight that states are increasingly moving towards developing more community-based

long-term support and services options. This movement is due in part to the recognition of consumer preferences for community-based care, but also due to a greater awareness of state obligations under the Americans with Disabilities Act, as highlighted by the 1999 Supreme Court Olmstead Decision and supported by the President's New Freedom Initiative.

Through this contract, CMS has developed approximately 50 short papers on promising practices and a number of in-depth case study reports, which are posted on the CMS website and distributed at various conferences and meetings. In addition, our contractor has presented information and provided technical assistance under this contract at national conferences and meetings for states audiences.

Ongoing Collection & Analysis of State Data for LTC Services
Project No.: Contract# 500-96-0006, Task Order #2
Period: 9/30/01 - 9/29/04
Funding: $520,000 + $720,000
Award: Task Order
Principal Investigator: Brian Burwell
Awardee: Medstat
CMS Project Officer: Kay Lewandowski, x61584
Description:
In response to the U.S. Supreme Court decision in Olmstead vs. L.C., and in support of the American's with Disabilities Act of 1990 (ADA), the Department of Health and Human Services has urged States to increase access to community-based services for individuals with disabilities by developing comprehensive and effective working plans for ensuring compliance with ADA.

CMS and the States are challenged to demonstrate significant improvements in community systems for long term care for people with disabilities. In order to accomplish this, there must be a clear understanding of the delivery system for long term care services as it currently exists, and how it progressively changes, as initiatives to increase access to community-based services for individuals with disabilities are implemented.

Both CMS and the States lack even rudimentary information about long term care trends. In response to this need, a system is being developed to provide point in time and longitudinal State-specific long term services information. Specifically, the Waiver and Grant Management System (WGMS) developed by this task will play an important role in the Center's responsibilities under the ADA and the Olmstead Decision, and will support the President's New Freedom Initiative by (1) enabling CMS to better manage its home and community based services waiver and grant programs and other long term care services, and (2) ascertain progress States are making toward increasing the availability of community care opportunities for individuals with disabilities and the development of more accessible system of cost effective community based care.

Increase Adequacy & Availability of Personal Assistance Services
Project No.: 500-96-0006, Task Order #2
Period: 9/30/01 – 9/29/03
Funding: $400,000
Award: Task Order
Principal Investigator: Brian Burwell
Awardee: Medstat
CMS Project Officer: Carey Appold, x62117
Description:
The goals of the tasks under this contract are to identify key elements, lessons learned and promising practices in the ability to recruit and retain personal assistance service workers; analyze and disseminate the information; and develop tools for subsequent steps. Specifically, Medstat is evaluating strategies and policies that will assist States to address the long-term care workforce shortage among personal assistance service providers.

Performance Benchmarking
Project No.: Contract# 500-96-0006, Task Order #2
Period: 9/30/01 - 9/29/04
Funding: $400,000
Award: Task Order
Principal Investigator: Brian Burwell
Awardee: Medstat
CMS Project Officer: Kay Lewandowski, x61584
Description:
The original intent of this task order was to develop benchmarks or measures for use by States to evaluate performance under Olmstead. But after review by CMS staff, and discussion with the States, it was decided that a more valuable approach would be to provide the tools to help each State develop its own benchmarks for measuring progress toward increasing the availability of and accessibility to home and community-based services for those in need of long term care.

This new approach was designed to include three forms of support to States. (1) In order for States to develop such benchmarks, a better understanding of the status of the long term care delivery system was needed. Funds originally designated for this "Performance Benchmarking" task were transferred to the "Ongoing Collection & Analysis of State Data for LTC Services" task to support the collection of this data. (2) States would be provided with additional guidance through access to the best practices developed under the "Collection, Analysis & Dissemination of Best Practices, State Planning/Infrastructure" task. (3) States would also have access to information under various CMS Quality initiatives to support development of State-specific quality monitoring and quality improvement strategies.

Research on the Results and Impact of Medicaid Buy-in
Project No.: CMS-02-010
Period: October 1, 2003 – September 31, 2004
Funding: $296,037
Award: Task Order
Principal Investigator: Henry Ireys
Awardee: Mathematica Policy Research, Inc.
CMS Project Officer: Joe Razes, x66126
Description:
Recent legislation expanded state opportunities to use Medicaid as a vehicle for supporting the competitive employment of people with disabilities. The Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) have permitted states to implement a Medicaid Buy-in that extends Medicaid coverage to working people with disabilities who, because of earnings, would not otherwise qualify for Medicaid under other statutory provisions.

The new Medicaid buy-in legislation offers increased incentives to people with disabling conditions to work and increase earnings without risking the potential loss of health care coverage. As more States implement Medicaid Buy-in programs, Medicaid work incentives systems are becoming increasingly important to understand.

Medicaid Infrastructure Grant Program
Project No.: Multiple
Period: October 2000 – December 31, 2011
Funding: $17,013,882 + $21,228,186
Award: Grant
Principal Investigator: Multiple
Awardee: Multiple (41 states and the District of Columbia)
CMS Project Officer: Joe Razes, x66126/Jeremy Silankis, x61592
Description:
This project collects, analyzes, and interprets data regarding States' Medicaid health systems development activities for individuals with disabilities and will develop a performance monitoring tool. This tool would be used by states in evaluating the success of their buy-in programs. Recent legislation has offered States unprecedented opportunities to use Medicaid as a vehicle for supporting the competitive employment of people with disabilities. The Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) have permitted States to implement a Medicaid buy-in that extends Medicaid coverage to working people with disabilities [who, because of earnings would not otherwise qualify for Medicaid coverage under other statutory provisions]. The new Medicaid buy-in offers new incentives to people with disabilities to work and increase earnings without risking the potential loss of health care coverage. The goal of this project is to lay the groundwork for:

The rules and guidelines for implementing a state buy-in program are complex. While States have a tremendous amount of flexibility in how they design a Medicaid buy-in program they also spend much time examining issues of health care access and barriers to

the employment for people with disabilities. The data and design characteristics considered in their planning process ultimately influence the program that is developed and possible outcomes. The options available to States coupled with the array of rules to be followed can be confusing. Realizing the technical nature of the Medicaid buy-in programs and the fact that state staff often do not have the expertise, we have encouraged the development of two technical assistance partnerships. The primary purpose of these partnerships is to exchange information and ideas that will encourage states to take advantage of the Medicaid buy-in opportunities. As more States implement Medicaid buy-in programs nationally increased technical assistance is needed. Part of this is help with data collection and development of analytical tools to assess the results and impact of the Medicaid buy-in.

Demonstration to Maintain Independence and Employment Grant Program
Project No.: Multiple
Period: October 2000 – December 2006
Funding: $4,811,750 + 4,264,561
Award: Grant
Principal Investigator: Multiple
Awardee: Multiple (Mississippi, Texas, Rhode Island, District of Columbia)
CMS Project Officer: Joe Razes, x66126/Jeremy Silankis, x61592
Description:
This project collects, analyzes, and interprets data regarding States' Medicaid health systems development activities for individuals with disabilities and will develop a performance monitoring tool. This tool would be used by states in evaluating the success of their buy-in programs. Recent legislation has offered States unprecedented opportunities to use Medicaid as a vehicle for supporting the competitive employment of people with disabilities. The Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) have permitted States to implement a Medicaid buy-in that extends Medicaid coverage to working people with disabilities [who, because of earnings would not otherwise qualify for Medicaid coverage under other statutory provisions]. The new Medicaid buy-in offers new incentives to people with disabilities to work and increase earnings without risking the potential loss of health care coverage. The goal of this project is to lay the groundwork for:

The rules and guidelines for implementing a state buy-in program are complex. While States have a tremendous amount of flexibility in how they design a Medicaid buy-in program they also spend much time examining issues of health care access and barriers to the employment for people with disabilities. The data and design characteristics considered in their planning process ultimately influence the program that is developed and possible outcomes. The options available to States coupled with the array of rules to be followed can be confusing. Realizing the technical nature of the Medicaid buy-in programs and the fact that state staff often do not have the expertise, we have encouraged the development of two technical assistance partnerships. The primary purpose of these partnerships is to exchange information and ideas that will encourage states to take advantage of the Medicaid buy-in opportunities. As more States implement Medicaid buy-in programs nationally increased technical assistance is needed. Part of this is help

with data collection and development of analytical tools to assess the results and impact of the Medicaid buy-in.

Medicaid Payment Accuracy Measurement
Project No.: Multiple
Period: 9/01 - present
Funding: $2,476,345 + $2,618,334
Award: Task Order, Modification, Grant
Principal Investigator: CMS and Participating States
Awardee: States participating in pilot project
CMS Project Officer: Wayne Slaughter, x60038
Description:
This project is the heart of a CMS initiative to create a Medicaid and State Children's Health Insurance Program (SCHIP Payment Accuracy Measurement methodology and system. The pilot study was designed to: (1) research State efforts to date to measure payment accuracy in the Medicaid program; (2) develop, with interested States, a Payment Accuracy Measurement (PAM) methodology that can be used to develop both State-specific and national payment error rates for the Medicaid and SCHIP programs; and (3) lay the groundwork for implementation of a national PAM program aimed at systematic measurement and reduction of erroneous payments in these two major programs.

In FY 2001, CMS conducted basic research in the field of Medicaid PAM, and solicited State interest in this collaborative project. Nine States submitted applications, each proposing to develop and test a different PAM methodology. CMS approved all nine pilots, which were conducted in FY 2002. Also during FY 2002, CMS worked with the pilot States and The Lewin Group to develop a draft model PAM methodology that could be used by all States, notwithstanding State-to-State variations in program eligibility, service coverage and reimbursement policies. The model was designed for application to both fee-for-service and capitated managed care environments. Late in FY 2002, CMS solicited State applications to test the draft PAM model in FY 2003. Twelve States applied and were approved to test the national model.

Madonna Rehab. Center in Lincoln
Project No.: 18-P-91812/7-01
Period: 9/30/02 - 9/29/04
Funding: $200,000
Award: Grant
Principal Investigator: Bill Shuart, Ph.D.
Awardee: Madonna Rehabilitation Hospital, Lincoln, NE
CMS Project Officer: Peggy Clark, x65321
Description:
An Act making appropriations to DHHS for FY2002 required that CMS award $200,000 of its appropriations for research, demonstration and evaluation activities "to the Madonna Rehabilitation Center in Lincoln, Nebraska to create a new standard of rehabilitation practice and program design for children and adults with disabilities."

The funds will be used as partial support for these three separate research projects:

-Study 1 is a clinical trial to determine the effectiveness of body-weight supported treadmill training of patients. The goal of training is to improve the walking ability of patients who are in the chronic phase of recovery following a stroke.
-Study 2 is a clinical trial to explore the impact of constraint-induced therapy on upper extremity functioning for patients experiencing hemi-paresis following a stroke. This study will use motion analysis equipment.
-Study 3 will assess the cognitive functioning of patients who are in rehabilitation. This study is underway, and is in the data collection phase. The research is a one-group design that is followed over time with four discrete interviews. The first interview occurs in the pre-discharge phase and is followed by a serious of discrete, post-discharge telephone interviews.

CMS outlined two approaches for Madonna's consideration and they chose to use the grant money for staff training for the three studies, the purchase of equipment, and for expanded support for the execution, analysis and dissemination of the results of Study 3.

A 12-month no cost extension was approved on August 19, 2003. The project period will run from 9/30/2002 through 9/29/2004.

Santa Clara County, CA for Outreach of Its Children's Health Initiative
Project No.: 18-P-91722/9-01
Period: 07/01/02 – 6/30/03
Funding: $590,000
Award: Grant
Principal Investigator: Margo Maida
Awardee: Santa Clara Valley Health & Hospital System
CMS Project Officer: Chris Howe, x62005
Description:
This money will be used for the outreach and application assistance aspects of its Children's Health Initiative to demonstrate means of expanding enrollment of eligible children in Medicaid, SCHIP and other available health care programs. Through this outreach and enrollment project, workers and volunteers will educate families about health insurance coverage and discuss the benefits of health insurance for families with children and evaluate the families' eligibility. They will also address barriers to the application process by assisting the family in enrolling their child/children in the appropriate health insurance program (Medi-Cal, Healthy Families, or Healthy Kids).

Fishing Partnership Health Plan
Project No.: 18-P-91719/1-01
Period: 08/01/02 – 07/31/03
Funding: $800,000
Award: Grant
Principal Investigator: J. J. Bartlett
Awardee: Fishing Partnership Health Plan
CMS Project Officer: Chris Howe, x62005
Description:
The Fishing Partnership Health Plan (FPHP) is an innovative approach to expanding accessibility to affordable, high-quality health care coverage for an industry that is experiencing tremendous financial problems. A survey conducted in 1996 revealed that 43% of fisherman suffered without health care coverage. This rate is four times the state average. The requested funding will allow FPHP to cover at least an additional 100 fishing families who will benefit from a reduction of 40% in their monthly premiums. In addition, the funding will allow for the development of a premium subsidy reserve, which will ensure the program's long-term sustainability.

Increase Access to Health Coverage by Minorities Through Partnerships w/HBCUs—South Carolina Project—Outreach to Rural and Underserved Communities Project

Project No.: (1) CMS-02-00317, (2) CMS-02,00356, (3) CMS-02-00345, (4) CMS-02-00348, (5) Now handled by OPA
Period: (1) 9/13/03 – 8/13/03, extension to 11/31/03; (2) 9/17/03 – 6/30/03, extension to 12/31/03; (3) 9/11/03 – 6/30/03, extension to 8/30/03; (4) 9/12/03 – 6/30/03; (5) Now handled by OPA
Funding: $250,000
Award: Sole Source
Principal Investigator: (1) Sheila Ards, (2) Renee Gonzalez, (3) Anna McPhatter, (4) Alice Hines-Thomas, (5) Nancy Warneke
Awardee: (1) Benedict College, (2) Hispanic Association of Colleges and Universities (HACU), (3) Morgan State University, (4) Sojourner-Douglass College, (5) Salish Kootenai Tribal College
CMS Project Officer: Chevelle Thomas, x61387
Description:
The OTRUC project is a CMS collaboration with Historically Black Colleges and Universities (HBCUs), Hispanic Serving Institutions (HSIs), and Tribal Colleges (TCs) to develop targeted outreach projects that address the needs of rural and underserved communities. The projects are developed through partnerships with state Medicaid agencies, local agencies, and other community organizations.

The purpose of the project is to demonstrate how partnerships with HBCUs, HSIs, and TCs can assist CMS in achieving its broader goals, and test a model for helping States reduce racial health disparities.

Implementing New Freedom Executive Order
Project No.: 500-96-0006, Task Order #2
Period: 9/30/02 – 9/29/04
Funding: $249,953
Award: Modification
Principal Investigator: Brian Burwell
Awardee: Medstat
CMS Project Officer: Carey Appold, x62117
Description: The New Freedom Initiative Executive Order directed federal agencies to remove barriers to community-based care for elders and people with disabilities. One of the largest impediments to the expansion of community-based care is the shortage of direct service workers. CMS funded the continuation of a project developing recruitment and retention best practices, a supervisory curriculum for individuals wishing to direct their own care and a web-based return on investment calculator for use by state policy makers contemplating wage increases. The calculator is designed to help policy makers see the effect of a $1 increase in wages on other programs such as taxes, entitlements, home-ownership, etc. These efforts will help CMS provide technical assistance to states that are actively engaged in workforce reform projects.

CBC Submission for Senate Special Committee on Aging Report "Developments in Aging"

Implementation of Medicare Consumer Assessment of Health Plans Study
Prj #: 500-95-0057
Start Date: 01/1998
End Date: Option years to cover a 60 month period, until 09/2008.
Funding: $5,000,000 annually
Vehicle: Task Order
PI: Sherm Edwards
Awardee: Westat
PO: Amy Heller
Description: CMS annually surveys a sample of all Medicare beneficiaries and asks about their health care experiences using the Consumer Assessment of Health Plans Study (CAHPS) survey. To help Medicare beneficiaries understand their health plan options, CMS provides comparative information to beneficiaries, including quality performance measures and general information. CMS began this annual nationwide effort to survey Medicare beneficiaries in managed care plans about their experiences with plan performance in 1997. The Balanced Budget Act of 1997 mandates that CMS report plan information including general and comparative information to beneficiaries in print, over the phone, and on the Internet. Results are reported to Medicare beneficiaries on www.medicare.gov through *Medicare Personal Plan Finder* (CMS's database of comparative information on health plans), through 1-800 MEDICARE, through the *Medicare &You* handbook, and through a supplemental mailing in October 2001. The survey has achieved record response rates of over 80% each year, and overall findings indicate that Medicare managed care plan members are satisfied with their plan.
Status: In progress.

Implementation of Disenrollment Reasons Consumer Assessment of Health Plans Study Survey
Prj #: CMS-03-0021
Start Date: 01/1998
End Date: Option years to cover a sixty month period, until 09/2008
Funding: $3,000,000 annually
Vehicle: Task Order
PI: Judy Lynch
Awardee: Research Triangle Institute
PO: Amy Heller
Description: This contract will implement the 2004 administration of the Consumer Assessment of Health Plans Study (CAHPS) Disenrollment Reasons Survey to a sample of Medicare beneficiaries who have recently chosen to leave their Medicare managed care plan (Medicare+Choice and other plans) for each managed care contract eligible for inclusion in the survey. CMS has been administering the Reasons Survey since 2000. The Reasons Survey directly supports the 1997 Balanced Budget Act requirement that CMS report disenrollment rates to Medicare beneficiaries to promote informed choice.

Results of the survey are reported to Medicare beneficiaries on www.medicare.gov through *Medicare Personal Plan Finder* (CMS's database of comparative information on health plans), through 1-800-MEDICARE, and through the *Medicare & You* handbook. Results are also distributed to health plans and Quality Improvement Organizations for quality improvement activities and are used to support internal CMS monitoring.
Status: In progress.

Implementation of Medicare Fee-For-Service Consumer Assessment of Health Plans Study Survey
Prj #: 500-95-0061
Start Date: 09/2000
End Date: 09/2005
Funding: $3,000,000 annually
Vehicle: Task Order
PI: Bridget Booske
Awardee: University of Wisconsin
PO: Ted Sekscenski
Description: The Medicare Fee-for-Service (MFFS) Consumer Assessment of Health Plans Study (CAHPS) Survey collects information on Medicare beneficiaries who are enrolled in the Original Medicare plan, also referred to as Medicare fee-for-service (MFFS) Medicare. The survey collects information on an annual basis to fulfill a requirement of Congress (under the Balanced Budget Act of 1997) to provide information to Medicare beneficiaries on the quality of health services provided through MFFS and to compare this information to similar information collected from beneficiaries enrolled in Medicare managed care health plans. In the Fall of 2000, CMS funded the national implementation of the MFFS Survey, thereby providing the data to construct CAHPS ratings and composites for both the MFFS and Medicare+Choice populations. Comparative information from the CAHPS surveys is reported to Medicare beneficiaries so they can make more informed decisions when choosing a Medicare health plan.
Status: In progress.

National Medicare Education Program Assessment of Case Studies
Prj #: 500-01-0002/0007
Start Date: 10/1/2001
End Date: 12/31/2003
Funding: $1,493,632
Vehicle: Task Order
PI: Monica Marshall, Ketchum
Awardee: Ketchum Public Relations
PO: Suzanne Rotwein, Ph.D.
Description: As part of the National Medicare Education Program (NMEP), CMS provides information to people with Medicare about the Medicare program and their Medicare+Choice options. The Balanced Budget Act of 1997 mandated changes to Medicare including the expansion of health insurance options by the creation of Medicare+Choice. Performance assessment plays a critical part of CMS's efforts to provide this information. This project's goal is to assess the effectiveness of the NMEP at

the local level utilizing case study sites around the country. The project's components included media monitoring of print and television, a telephone survey to randomly selected people with Medicare in the six case study sites, and site visits to these sites.
Status: Statistical analyses and evaluation of the case studies are ongoing.

Assessment of the Medicare & You Education Program
Prj #: 500-00-0037
Start Date: 09/10/2001
End Date: 09/30/2004
Funding: $4,651,736
Vehicle: Task Order
PI: Ken Cahill
Awardee: BearingPoint/Westat
PO: Lori Teichman
Description: The Balanced Budget Act of 1997 mandated changes to Medicare including the expansion of health insurance options by the creation of Medicare+Choice. To support the new program and help Medicare beneficiaries make more informed health care decisions, CMS initiated the National Medicare Education Program (NMEP) The NMEP employs numerous communication vehicles, including the *Medicare & You* handbook, 1-800 MEDICARE, the State Health Insurance Program (SHIP), www.medicare.gov, and the REACH program to educate beneficiaries and help them make more informed health care decisions. The Assessment of the Medicare & You Education Program contract includes the assessment of key elements of CMS's NMEP program: the Nursing Home Quality Initiative, the REACH program, the SHIP program, 1-800 MEDICARE, and the *Medicare & You 2002* handbook. The intent of the assessment is to promote continuous quality improvement in how CMS communicates with beneficiaries and those acting on their behalf.
Status: In progress.

State Health Insurance Program
Prj #: Various (one for each participating state)
Start Date: 09/29/1992
End Date: Ongoing (curtrent grant cycle is April 1 through March 31
Funding: Approximately $12,000,000 annually
Vehicle: Grants
PI: N/A
Awardees: All fifty states plus Washington, D.C., Puerto Rico, and the Virgin Islands
PO: Eric Lang
The State Health Insurance Program (SHIP) is a program of grants from CMS to states, mandated by Section 4360 of the Omnibus Budget Reconciliation Act of 1990, which directs the Secretary of Health and Human Services to award grants to states to provide information, counseling, and assistance to people with Medicare. Its purpose is to give people with Medicare access to person-to-person assistance on health insurance problems that require in-depth knowledge of local programs and services that can result in a more individually focused and complete solution to the problem or question. SHIPs are expected to provide people with Medicare help on a wide range of health insurance topics, including Medigap, long-term care insurance, and managed care, and refer them to

appropriate expert advice. As a program built on volunteer service, SHIPs can provide peer counseling to people with Medicare in settings where they live and congregate and help translate complex public and private health insurance language into understandable terms that fit individual circumstances. SHIPs use innovative approaches to reach people with Medicare unable to access information due to cultural differences and language, location, and literacy barriers, including the use of interpreters during telephone calls and presentations, counseling at sites in ethnic neighborhoods, site visits in remote areas of a state, and recruiting volunteer counselors in hard to reach communities. CMS monitors grantee performance through a standardized performance reporting system that requires SHIPs to collect client contact and other program data. Data shows that annually more than one million persons with Medicare receive free counseling and another million receive help through group presentations.
Status: In progress.

CBC

Implementation of Medicare Consumer Assessment of Health Plans Study
Prj #: 500-95-0057
Start Date: 01/1998
End Date: Option years to cover a 60 month period, until 09/2008.
Funding: $5,000,000 annually
Vehicle: Task Order
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Awardee: Westat
PO: Amy Heller
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Awardee: Research Triangle Institute
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through *Medicare Personal Plan Finder* (CMS's database of comparative information on health plans), through 1-800-MEDICARE, and through the *Medicare & You* handbook. Results are also distributed to health plans and Quality Improvement Organizations for quality improvement activities and are used to support internal CMS monitoring.
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End Date: 09/2005
Funding: $3,000,000 annually
Vehicle: Task Order
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Awardee: University of Wisconsin
PO: Ted Sekscenski
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included media monitoring of print and television, a telephone survey to randomly selected people with Medicare in the six case study sites, and site visits to these sites.
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peer counseling to people with Medicare in settings where they live and congregate and help translate complex public and private health insurance language into understandable terms that fit individual circumstances. SHIPs use innovative approaches to reach people with Medicare unable to access information due to cultural differences and language, location, and literacy barriers, including the use of interpreters during telephone calls and presentations, counseling at sites in ethnic neighborhoods, site visits in remote areas of a state, and recruiting volunteer counselors in hard to reach communities. CMS monitors grantee performance through a standardized performance reporting system that requires SHIPs to collect client contact and other program data. Data shows that annually more than one million persons with Medicare receive free counseling and another million receive help through group presentations.
Status: In progress.

U.S. FOOD AND DRUG ADMINISTRATION ACTIVITIES FOR CALENDAR YEARS 2001 AND 2002 ON BEHALF OF OLDER AMERICANS

INTRODUCTION

As the percentage of older Americans in the Nation's population continues to increase the Food and Drug Administration (FDA) has been giving increasing attention to the elderly in the programs developed and implemented by the agency.

Some of the challenges associated with older Americans, such as multiple drug interactions, food safety, different physiological characterizations and reactions to drug regimens, and the need for better medical device design for home self-diagnostics and therapies, will become more acute. These challenges will require greater inclusion of the elderly in clinical testing for drugs, medical devices, and other FDA-regulated products. Further, the increasing educational needs of the elderly will require more focused educational programs, including specific dietary information and foods targeted to their nutritional requirements. The elderly population and food service workers who prepare food for the elderly also will require special education initiatives concerning proper food handling because as the population ages it becomes more susceptible to foodborne diseases. Some of the major initiatives that are underway are described below.

MISSION

FDA is a regulatory consumer protection agency whose mission is to promote and protect the public health by providing timely clearance of safe and effective products and monitoring products for continued safety after they are in use. The agency's primary responsibilities are to ensure that: (1) foods are safe, nutritious, wholesome, and honestly labeled; (2) cosmetics are safe and properly labeled; (3) all drug products used for preventing, diagnosing, and treating disease are safe and effective, and information on their proper use is available; (4) biological products (blood and blood products, test kits, vaccines and antigens, therapeutic agents, and other biologicals) are safe, potent, and effective for the prevention, diagnosis, and treatment of disease; (5) medical devices are safe, effective, and properly labeled, and the public is not exposed to excessive radiation from medical, industrial, and consumer products; (6) animal drugs, devices, and feeds are safe and effective; and (7) food from animals that are administered drugs are safe for human consumption.

FDA performs its mission mainly through enforcement of the Federal Food, Drug, and Cosmetic Act and regulations that implement its provisions. FDA's current areas of emphasis are to implement the Food and Drug Administration Modernization Act of 1997 (FDAMA), to strengthen the agency's science-base, and to implement the Administration's initiatives on food safety and blood safety.

LEVERAGING PARTNERSHIPS

Leveraging is the creation of relationships or formal agreements with others outside the FDA, which will eventually enhance the agency's ability to meet its public health mission. By choosing to work with other organizations that share similar public health and safety goals, FDA can significantly amplify its public health impact, leverage the intellectual capital of others, and make wise use of its resources.

FDA has formed many leveraging partnerships with other government agencies, regulated industry, academia, health providers, consumers, and national and community based organizations to help the agency meet its public health responsibilities. As part of the agency's long-standing tradition of involving the public in its activities, FDA is forging new relationships with organizations in the aging network on national and grassroots levels.

The agency has been successful with its collaborations, and FDA intends to expand and build on this foundation in developing new partnerships. During 2001 and 2002, the agency conducted various activities to establish and strengthen two-way communication between FDA and its constituencies. These activities included national and local consumer roundtables, meetings with organizations, stakeholder meetings, and public meetings.

PUBLIC PARTICIPATION

FDA has processes that provide access to decision-making and information programs by its stakeholders. FDA's stakeholders include industry, small business, consumers, and health professionals. Stakeholders may interact with FDA policy makers, express opinions, or ask for information to address specific concerns. FDA provides balanced opportunities for public access to the pre- and post-market regulatory processes as well as timely education and information.

FDA convened a series of national and local roundtables and stakeholder meetings with consumers, health professional associations, and community-based organizations. These forums provide opportunities for the agency to dialogue with diverse groups on the FDA Modernization Act and an array of regulatory and health policy issues. One of the issues addressed was risk management associated with the use of medical products, a significant matter of interest for the older American community.

ADVISORY COMMITTEES

One of the ways the agency makes an effort to involve older Americans in its activities is through its advisory committees process. Advisory committees have served an important role at FDA for decades in helping the agency make sound decisions based on good science. Advisory committees consist of individuals who are recognized as experts in their field, including clinical professionals, scientists and researchers, industry leaders, consumer representatives, and patient representatives. Currently, 29 advisory committees serve the agency. Their recommendations are highly valued by FDA officials. Although FDA always considers these recommendations, they are not binding. FDA makes the final regulatory decisions.

HEALTH FRAUD

Health fraud is the deceptive promotion and distribution of false and unproven products and therapies to diagnose, cure, mitigate, prevent, or treat disease. These fraudulent practices can be serious and often expensive problems for the elderly. Besides economic loss, health fraud can also pose direct and indirect health hazards to those who are misled by the promise of quick and easy cures and unrealistic physical transformations.

The elderly are often the victims of fraudulent schemes. Almost half of the people over 65 years old have at least one chronic condition, such as arthritis, hypertension, or a heart condition. Therefore, senior citizens provide promoters with a large, vulnerable market. To combat health fraud, FDA uses a combination of enforcement and education. The agency decides on appropriate enforcement action

based on factors such as the health hazard potential of the product, the extent of its distribution, the nature of mislabeling, and other agencies' jurisdiction.

FDA has developed a priority system of regulatory action based on two general categories of health fraud: direct health hazards and indirect hazards. The agency regards a direct health hazard to be extremely serious, and it receives the agency's highest priority. FDA takes immediate action to remove such a product from the market. When the fraud does not pose a direct health hazard, the FDA may choose from several regulatory options to correct the violation, such as a warning letter, a seizure, or an injunction.

The agency also uses education and information to alert the public to health fraud practices. Both education and enforcement are enhanced by coalition-building and cooperative efforts between government and private agencies at the national, state, and local levels. The agency also evaluates enforcement and education initiatives to see that they are correctly focused.

The health fraud problem is too big and complex for any one organization to combat effectively by itself. Therefore, FDA is working closely with many other groups to build national and local coalitions against health fraud. By sharing and coordinating resources, the overall impact of efforts to minimize health fraud will be significantly greater. FDA is leveraging resources with the Federal Trade Commission (FTC) to target Internet health fraud. This initiative, "Operation Cure-All," is aimed at false and misleading claims, fraudulent and unproven "miracle" cures.

FDA has worked with the National Association of Attorneys General and other organizations to provide consumers with information to help avoid health fraud. Since 1986, FDA has worked with the National Association of Consumer Agency Administrators (NCAA) to carry out a project called the NCAA Health Products. Information from the FTC, U.S. Postal Service, and state and local offices is provided to NCAA periodically to include in the Information Exchange Network. This system provides information on health products and promotions, consumer education materials for use in print and broadcast programs, and the names of individuals in each contributing agency to contact for additional information.

The Internet poses new and challenging problems to agency efforts to prevent health fraud. Snake oil salesmen of the past have abandoned their wagons to hop on the Internet with offers of eternal youth and potions for the prevention, treatment and cure of many diseases.

OFFICE OF PUBLIC AFFAIRS

The FDA's Office of Public Affairs (OPA) is the agency's primary point of contact for the news media. It also manages the agency's Web site at www.fda.gov and develops information materials on FDA-related public health and consumer protection activities. While working closely with the different centers within the agency, OPA publishes *FDA Consumer* magazines, articles, press releases, and talk papers, which focus on topics of interest and concern to older Americans.

The agency Web site has a page dedicated to older Americans entitled "FDA Information for Older People." This site gives information regarding buying medicines online, seniors and food safety, and linkages to other organizations outside FDA with information of interest to older Americans. This webpage also has many articles and other publications with information for older Americans on a wide range of health issues such as:

- Arthritis: Timely Treatments for an Ageless Disease
- Help Your Arthritis Treatment Work (Spanish Version)
- Preventing Colon Cancer
- FDA Sets Higher Standards for Mammography
- Lung Cancer
- Prostate Cancer: No One Answer for Testing or Treatment
- Health Claim for Foods That Could Lower Heart Disease Risk
- Keeping Cholesterol Under Control
- Taking Charge of Menopause
- Taking Time to Use Medicines Wisely
- How to Spot Health Fraud

OFFICE OF SPECIAL HEALTH ISSUES

The FDA's Office of Special Health Issues (OSHI) serves the public by answering their questions about the agency's activities related to HIV/AIDS, cancer, and other diseases. OSHI works with patients and their advocates to encourage and support their active participation in developing FDA regulatory policy. Also, OSHI alerts FDA staff to patient issues and viewpoints; responds promptly to individuals with life-threatening diseases and other issues; helps develop national policies and practices for HIV/AIDS, cancer, and diseases of special populations, and represents FDA at scientific and policy meetings.

OFFICE OF WOMEN'S HEALTH

FDA's Office of Women's Health (OWH) serves as a champion for women's health both within and outside the agency. To meet its goals, OWH does the following:

(1) ensures that FDA's regulatory and oversight functions remain gender sensitive and responsive;
(2) works to correct any identified gender disparities in drug, device, and biological testing and regulation policy;
(3) monitors the progress of priority women's health initiatives within FDA;
(4) promotes an integrative and interactive approach regarding women's health issues across all the organizational components of the FDA; and
(5) forms partnerships with government and non-government entities, including consumer groups, health advocates, professional organizations, and industry to promote FDA's women's health objectives.

OWH has tried to expand its inclusion of older Americans in their programs. Examples include:

Menopause and Hormones Information Campaign – In March 2003, OWH began a nationwide menopausal hormone therapy information campaign, collaborating with FDA's Center for Drug Evaluation and Research, several HHS agencies (NIH, AHRQ, and CDC), and over 20 outside organizations. The goal is to distribute clear, labeling-based educational materials (fact sheet, purse guide, and public service announcement), and to publicize federal Web sites with information about menopause and the risks and benefits hormone replacement to relieve menopausal symptoms. All print and Web-based resources recommend that women discuss menopausal hormone therapy with their doctors to determine if these products are appropriate for them. If so, the advice is to use the lowest possible dose for the shortest period of time to manage menopausal symptoms. The official campaign "roll-out" took place on September 9, 2003. OWH staff are attending many annual professional meetings this fall to raise awareness about the campaign and disseminate materials.

Take Time To Care (TTTC) … About Diabetes -The greatest increase in diabetes cases over the next 50 years will be among those over 75 years old – a projected increase of 336 percent. A woman age 65 today is likely to live at least another 20 years, long enough to develop complications if diabetes is not prevented. As both life expectancy and the number of older adults increases, trying to prevent diabetes among older adults becomes increasingly important. FDA's OWH developed a public awareness campaign about the looming epidemic of diabetes and pre-diabetes. These conditions affect 34 million Americans, more than half being women. The campaign, "Take Time to Care (TTTC)…About Diabetes" co-sponsored by the American Diabetes Association and the National Association of Chain Drug Stores was launched for one month in May 2002 in 11 cities. Over 5 million brochures in English and Spanish were distributed. Five nurses organizations helped to reach over 50,000 people in high-risk communities. ADA provided support in 80 field offices throughout the country and access to their 1-800-DIABETES hot line number. Over 32 stores were represented with 3,200 outlets. This national campaign is continuing, and will be re-launched in 10 new cities in February of 2004. It will also focus on the cardiovascular complications associated with diabetes.

Pink Ribbon Sunday – The FDA is sponsoring a Pink Ribbon Sunday mammography initiative, an outreach program that targets African-American and Hispanic women, who have a disproportionately low turnout for mammography screening. In Houston, 150 churches working with the FDA have delivered the message "Early Detection Saves Lives" to 110,000 people.
New Publications – FDA's OWH created over 25 new fact sheets for distribution to consumers, including older adults, which will provide accurate, useful and easily accessible information about medications and other FDA regulated products. OWH continues to offer a quarterly newsletter for consumers focusing on FDA actions, meetings, and activities of interest to women across the lifespan.

OWH Web site – FDA's OWH is redesigning its Web site to make it more easy to navigate. It will also include issues important to older adults, such as HRT, diabetes, medication management, dietary supplements, depression, influenza, heart disease, stroke, and lung cancer. This Web site received the "Hot Site Award."

Speaking and Exhibiting – FDA staff present and exhibit various subjects at national aging-related conferences, such as the Gerontological Society of America, AARP, and the joint American Society on Aging/ National Council on the Aging annual conference.

Other Outreach Projects (for delivery in FY 2004). OWH funded grants:

- Educating senior and Hispanic women about diabetes and its relationship to cardiovascular disease, health risks, appropriate treatments, and lifestyle changes.
- Co-sponsor of the 4th annual women's health summit in Atlanta, Georgia. The Summit highlighted FDA's regulatory oversight in the areas of mammography quality standards Act, (MQSA), Pink Ribbon Sunday, Take Time to Care…About Diabetes, and Menopausal Hormone Therapy.
- Co-sponsor the South Carolina Statewide Cancer Outreach Initiative – a collaborative effort with the FDA/Office of Women's Health, The Breast Cancer Resource Committee, the American Cancer Society, and an exhaustive group of community organizations. The statewide education program includes all cancers, but focuses on breast cancer (to increase mammography screening, particularly among minority and underserved populations, and to identify low-income women who need breast cancer services.
- Implement a mammography outreach program targeting African-American, Native American, Hispanic, Vietnamese, Bosnian, and rural women.
- Offer Pink Ribbon Sunday events, such as leadership orientations and train-the-trainer sessions for health care advocates from African-American and Hispanic faith-based communities.

- Co-sponsor the "Minnesota Plan for Diabetes 2010." This event will launch Minnesota's new 10-year plan for diabetes prevention and raise awareness and interest in the plan, as well as encourage partners to participate in its implementation.

Other OWH Funded Projects:

- Working with Native American groups to increase their awareness about diabetes, heart disease and obesity. The project will promote personal responsibility in managing these diseases.
- A campaign throughout Puerto Rico to raise awareness about diabetes using Spanish TTTC...About Diabetes materials, and a 2-day statewide conference to train 250 health professionals and health educators about diabetes and obesity.
- Providing translations and assistance to Asian-American and Pacific Islander (AAPI) communities. Translations were provided for TTTC...About Diabetes, Medication Management, and Nutrition Labeling brochures in 11 different AAPI languages.

OFFICE OF ORPHAN PRODUCTS DEVELOPMENT

It is the intent of the Orphan Drug Act and the Office of Orphan Products Development (OPD) to stimulate the development and approval of products to treat rare diseases. The OPD plays an active role in helping sponsors meet agency requirements for product approval. From 1983 – when the Orphan Drug Act was passed – through the end of 2002, 232 products to treat small populations of patients were approved by FDA.

By the end of 2002 there were 1,202 designated orphan products. One hundred fifty-three of these designated orphan products (13 percent) represent therapies for diseases predominately affecting older Americans. Ninety-two are for treating rare cancers in the elderly, such as pancreatic cancer, and metastatic melanoma. Twenty-three of the orphan products designated for treating elderly populations are for rare neurological diseases, such as amyotrophic lateral sclerosis (ALS), and advanced Parkinson's disease. Thirty-one orphan-designated therapies for elderly populations have received FDA market approval. Most noteworthy among these is Eldepryl™ for treatment of idiopathic Parkinson's disease, postencephalitic Parkinsonism, and symptomatic Parkinsonism; Novantrone™ for treatment of refractory prostate cancer; and Gleevec™ for treatment of chronic myelogenous leukemia.

FDA's orphan product grants had their beginning in 1983 as one of the incentives provided by the Orphan Drug Act. This program provides financial support for clinical studies (clinical trials) to determine the safety and efficacy of products to treat rare disorders, and to achieve marketing approval from the FDA under the Federal Food, Drug, and Cosmetic Act. Studies funded by the orphan products grant program have contributed to the marketing approval of thirty-three products.

Because the orphan products program is issue-specific/indication-specific, it is typical for an approved product to be funded under the orphan products grant program for study in an indication unique to a distinct group of people, such as women, children, or the elderly. Under the orphan drug program, disease populations are small and in many instances the firms themselves are very small. The goal of the Orphan Drug Act is to bring to market products for rare diseases or conditions. In so doing, orphan product development promotes research and labeling of drugs for use by and for special populations. The orphan products grant program has funded more than 50 studies aimed at treatment of diseases affecting adults and older adults.

PUBLIC AFFAIRS SPECIALISTS IN FIELD OFFICES

Public Affairs Specialists (PASs) are located throughout the country in FDA field offices. The goal of the PAS program is to promote the agency's mission to protect the public health of the nation. PASs participate in diverse outreach activities to update and educate the agency's stakeholders on a multitude of important public health issues. PASs also respond to consumer questions about the agency, its authorities, activities, and the products it regulates.

The agency has established networks and communication channels to reach the national and local aging network with consumer-oriented information. FDA collaborate with its constituencies – consumers, patients, health professionals, academia and scientific organization, industry, women's organizations minority groups, and the international community – to extend its outreach to older Americans and their health care providers.

PASs have conducted various community-based programs in 2001-2002 to address the health concerns and information needs of older Americans. The agency also staffs exhibits at major annual meetings of national organizations, as well as at community events and local health fairs sponsored by grassroots organizations. The following summaries are representative of their activities but are by no means comprehensive lists of their activities involving older Americans. Topics of field programs, exhibits, training activities, and speeches were mainly food safety, diabetes awareness, women's health, Take Time To Care, mammography, seafood safety, Internet sales of medical products, and prescription drugs from Canada and Mexico.

- PAS (Denver) gave a presentation to a group of older visually impaired Americans who on the roles and responsibilities of FDA.
- PAS (Denver) gave two workshops for senior center nutrition specialists on current food safety updates for older Americans.
- PAS (Denver) worked with the Navajo Area Agency on Aging to provide food safety materials to attendees at the 2002 Dine' Conference on Aging.
- PAS (Denver) staffed an exhibit at a health fair at a retirement center and provided consumer education materials to older adult residents.
- PAS (Nashville) served on the Tennessee Aging Advocacy Committee, which provided networking opportunities to get FDA information into the hands of multiple organizations that serve the aging in Tennessee.
- PAS (Nashville) participated in the Better Business Bureau Scam Jams for seniors in northern Alabama. The events are put together locally to serve as a forum for officials from FDA and other federal and state agencies to talk with seniors about scams that are perpetrated on this special audience.
- PAS (San Francisco) presented Take Time To Care information to seniors at a Buddhist Temple, with both Japanese and English versions of brochures distributed to attendees.
- PAS (San Francisco) presented the Take Time To Care message at a meeting of the Social and Health Agency Research Exchange organizations. Participants were various public and private senior advocates.
- PAS (Indianapolis) provided FDA information on food safety, nutrition, and prescription and over-the-counter drugs to senior citizen groups.
- PAS (Cincinnati) staffed an exhibit at the annual Senior Health Fair, featuring posters and brochures on pharmaceuticals and food safety.
- PAS (Detroit) gave a presentation on preventing medical gas mixups and presented training to directors of nursing at nursing homes.
- PAS (Indianapolis) staffed an exhibit at the Indiana State Fair that focused on senior citizen issues.

- PAS (Milwaukee) gave presentations to senior citizens on prescription versus over-the-counter drugs, food safety, the drug approval process, food security, and health fraud.
- PAS (Raleigh) gave a presentation to a group of senior citizens at Duke University on food safety, with a look back on historic home food handling practices.
- PAS (Los Angeles) staffed an exhibit at the AARP conference, featuring on Take Time To Care, diabetes, and My Medicines for Seniors materials.
- PAS (San Francisco) gave a presentation on food safety to the area senior coordinating council, retired health professionals, and senior citizens, and also touched on BSE, bioengineered and organic foods, bioterrorism and food security.
- PAS (San Francisco) promoted the senior Food Safety Program Initiative and provided information on diabetes and using medicines wisely.
- PAS (San Francisco) made a presentation on "senior" health fraud that addressed the issues of dietary supplements, the over-the-counter drug label, and MedWatch.
- PAS (Cincinnati) staffed a booth at the Senior Expo, sponsored by the Council on Aging.
- PAS (Milwaukee) gave presentations to senior citizens on drug safety, dietary supplements, food safety, the drug approval process, internet sales, importing drugs, generic versus brand name drugs, and prescription drug advertising.
- PAS (Florida) conducted a workshop entitled, "Elder Nutrition and Food Safety Curriculum," with the Extension Service.
- PAS (New Orleans) staffed exhibits and conducted workshops with senior citizen groups on diabetes awareness and other topics.
- PAS (Dallas) staffed an exhibit on diabetes at the Triad Symposium and Health Fair, working with seniors to help enrich their lives and their community and distributed publications on mammography, ovarian cancer, prostate cancer, and buying drugs online.
- PAS (Houston) conducted workshops for seniors that covered food safety, over-the-counter drug labeling, the drug approval process, internet sales, and health fraud.
- PAS (San Francisco) presented the Take Time To Care message to a group of Vietnamese senior citizens, using the services of an interpreter.
- PAS (San Francisco) joined crime prevention advocates as a presenter at the Senior Fraud Prevention Forum. The presentation covered language used by health fraud promoters, the dangers of unproven products and treatments, and how to get more information.
- PAS (Milwaukee) spoke to senior citizens about medical devices, food safety, dietary supplements, BSE, and prescription drugs.
- PAS (Milwaukee) presented FDA information on nutrition, dietary supplements, food safety and food labeling to senior citizen groups.
- PAS (Dallas) staffed an exhibit at the AARP national convention.
- PAS (Indianapolis) staffed an FDA exhibit at the Indiana Governor's 46th annual Conference on Aging, called "The Many Faces of Aging."
- PAS (San Francisco) staffed an exhibit at the 31st annual AARP Senior Rally, with a focus on drug safety.
- PAS (Raleigh) addressed seniors at the Carolina East Mall in Greenville, N.C., on nutrition and food labels, in a program sponsored by the local hospital.
- PAS (Raleigh) staffed an exhibit and interacted with seniors at the Pitt County Elder Fair, focusing on food safety – "From List to Leftovers."
- PAS (Raleigh) spoke to seniors on the importance of mammograms in breast care.
- PAS (Raleigh) spoke at a meeting for seniors hosted by Congressman Etheridge on the wise and safe use of medicines and on drug interactions.

PASs regularly speak with media representatives, give interviews and provide background information for newspapers, magazines, newsletters, and radio and television reporters.

- PAS (Raleigh) gave a presentation on nutrition and weight loss to senior citizens that was taped by the local network affiliate. The station also interviewed the PAS on senior nutrition concerns.
- PAS (St. Louis) taped several interviews for a local senior citizen cable network that featured Internet drug sale and drug safety issues.
- PAS (Raleigh) spoke on the local network affiliate about breast cancer screening and the importance of mammograms for older women.

PAS activities were conducted in support of the national educational campaign, "Buying Medicines and Medical Products Online." They participated in many interviews and talk show programs. They visited radio and television stations and met with the health program directors to introduce them to FDA and provide them information packets about the campaign and FDA's regulatory responsibility.

- PAS (Minneapolis) gave several presentations and provided information to senior citizen groups who shared the informational brochures with homebound seniors.
- PAS (San Francisco) staffed an exhibit at a senior health fair and partnered with the AARP Campaign for Patient Safety that focused on drug safety.
- PAS (New Jersey) gave a presentation to the Southern New Jersey Council on Aging Senior Leaders.
- PAS (Milwaukee) gave presentations on Internet sales at several senior sites.
- PAS (San Francisco) staffed an exhibit at a health forum for seniors in commemoration of Older Americans Month.
- PAS (Baltimore) presented information at an AARP-sponsored health fair for seniors.
- PAS (Indianapolis) gave a presentation on Internet sales for seniors that included food safety.
- PAS (San Francisco) distributed educational materials to local government and community-based organizations for inclusion in their newsletters and publications.

THE NATIONAL CENTER FOR TOXICOLOGICAL RESEARCH

The mission of FDA's National Center for Toxicological Research (NCTR) is to conduct peer-reviewed scientific research that supports FDA's current needs and foresees future regulatory needs. This involves fundamental and applied research specifically designed to define biological mechanisms of action underlying the toxicity of products regulated by the FDA. This research is aimed at understanding critical biological events in the expression of toxicity and at developing methods to improve assessment of human exposure, susceptibility, and risk.

NCTR has worked with the National Institute on Aging in the past to study the role caloric restriction plays in the aging process. An offshoot of this research has led to studies dealing with the effect of age and food restriction on muscle glucose transport in Fischer 344 rats. Advancing age is characterized by a progressive deterioration of glucose homeostasis. Studying the effects of short-term and chronic food restriction on glucose metabolism will provide valuable insight into the possibility that glucose plays a role in primary aging.

The Center's Division of Neurotoxicity is studying the rat hippocampus using DNA microarrays a novel antibody array, and laser capture microdissection to determine the effect of aging on regional distribution of brain proteins in various animal strains. This experiment will determine exactly which gene/protein expressions are associated with normal aging and which with abnormal aging. Scientists working in the Center's Division of Genetic and Reproductive Toxicology Division have been studying the effects of

spontaneous mutation on human pathologies such as cancer, human genetic diseases and aging. In similar cancer and aging studies the correlation between these disease endpoints and levels of endogenous DNA oxidation have been studied.

The Center's multidisciplinary scientific staff has been studying the neurological disorders associated with Parkinson's and Alzheimer's diseases. Neurotoxicologists are investigating whether performance on a variety of behavioral tests is different between persons with mild to moderate Alzheimer's disease. Others are using nuclear magnetic resonance to look at the metabolic profiles from four key regions in the brains of patients definitely diagnosed with Alzheimer's There is considerable evidence indicating that mitochondrial dysfunction plays a major role in the etiology of complex neurodegenerative diseases such as: Alzheimer and Parkinson disease. A study is underway at NCTR that will help to uncover genomic links between mitochondria and a number of diseases or chemical toxicities that are associated with impaired mitochondrial function.

MEDWATCH

MedWatch, the FDA's voluntary Medical Products Reporting and Safety Information Program, serves both healthcare professionals and the medical product-using public. MedWatch strives to educate health professionals about the critical importance of being aware of, monitoring for, and reporting adverse events and product problems to FDA and/or the manufacturer, as well as to ensure that new safety information is rapidly communicated to the medical community, thereby improving patient care. The purpose of the MedWatch program is to enhance the effectiveness of postmarketing surveillance of medical products as they are used in clinical practice and to assist in rapidly disseminating information about significant health hazards associated with these products. Health professionals, as well as consumers, are encouraged to report serious adverse reactions and product problems associated with FDA-regulated products to the agency.

Older Americans are generally more susceptible to adverse events because of the probability they will use more medications and medical device products.

CENTER FOR DEVICES AND RADIOLOGICAL HEALTH

FDA's Center for Devices and Radiological Health (CDRH) promotes and protects the health of the public by ensuring the safety and effectiveness of medical devices and the safety of radiological products. Medical devices include products ranging from mechanical heart valves to ophthalmic lasers to pregnancy test kits – products that are intended to diagnose disease or other conditions, or to cure, mitigate, treat, or prevent disease. Radiation-emitting electronic products include microwave ovens, televisions, sunlamps, medical and baggage inspection x-ray machines, and laser products such CD and DVD players, light shows, and bar code scanners. CDRH provides information to consumers, including older Americans, regarding medical devices and radiation-emitting products to enhance their ability to avoid risk, achieve maximum benefit, and make informed decisions about the use of such products.

Mammography - Because a woman's risk for breast cancer increases as she gets older, the need to have a regularly scheduled mammogram is critical in detecting breast cancer in its earliest, most treatable stage. Congress passed the Mammography Quality Standards Act of 1992 (MQSA) to ensure that all women have access to quality mammography for the detection of breast cancer in its earliest, most treatable stages. In recent years mortality from breast cancer has continued to decline, in part because of high quality mammography combined with better treatment agents.

On December 27, 2002, there were 9,226 MQSA-certified mammography facilities in the United States and its territories. All of these facilities are subject to accreditation by outside expert bodies, and certification and inspection by FDA or a state approved by FDA to act as a certifying body, to ensure compliance with quality standards.

Efforts aimed towards older women:

- CDRH targets older Americans for particular outreach efforts. Groups such as AARP are invited to link to our web site and join our list serves to receive mammography information and updates, as well as view a yearly report on actions taken against mammography facilities which violate MQSA standards. Women can also search the mammography web site to find certified facilities by zip code.
- Collaboration with FDA's Offices for Women's Health, Consumer Affairs, Public Affairs, and Special Health Issues, has resulted in the distribution of mammography educational materials to their constituents, including newsletter editors.
- Older women were included in the outreach about the 1-800-4-Cancer hot line. Callers to this number can locate FDA-certified mammography facilities in their areas, get answers to questions about breast cancer and mammography, and request publications.
- Consumer representatives with ties to senior advocacy groups are members of FDA's National Mammography Quality Assurance Advisory Committee.

Hospital Bed Safety - Death and injury adverse events associated with patient entrapment in hospital beds continue to be reported to FDA. FDA led the Hospital Bed Safety Workgroup in partnership with hospital bed manufacturers, national healthcare organizations, patient advocacy groups, and the Veterans Administration. The workgroup intends to improve safety of hospital beds in all health care settings for patients most vulnerable to risk of death and injury from entrapment.

Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Setting, will be released in 2003. These guidelines are the first to provide uniform recommendations to help caregivers in hospitals, long term care facilities, and home care settings about patient safety and use of bed rails. The guidance can be adapted to meet the needs of patients in specific environments.

FDA's Web site for bed safety links to the clinical guidelines; www.fda.gov/cdrh/beds. In addition, FDA is developing dimensional guidelines, measurement tools, and educational materials for manufacturers, caregivers and consumers to identify and reduce risk of entrapment in new and existing hospital beds. The CDRH dimensional guidelines are expected to be released in 2004.

Surgical Stapler and Clip Applier - The Systematic Technology Assessment of Medical Products (STAMP) Committee convened in September 2001 to address adverse events associated with surgical staplers and clip appliers. The reported events described cutting and device component failures, resulting in pain, bleeding, tissue necrosis, hypovolemic shock, cardiac tamponade, and subsequent deaths. Surgical staplers and clip appliers are used in gastrointestinal, gynecologic, thoracic, and other surgeries to resect or transect tissues and to create anastomoses. These devices have been marketed for years and their use results in shortened surgical procedure times.

The STAMP committee includes representatives from CDRH and the American College of Surgeons (ACS). In addition to reviewing adverse event reports, the committee discussed adequacy of training programs for surgical staplers and clip appliers, reuse of single use staplers, and manufacturing/design issues. The ACS believes that reuse of single use staplers

is not an issue in the United States, but a common practice in Mexico, South America, Central Europe, and parts of Asia. Also, problems with surgical staplers and clip appliers are rarely discussed in professional meetings, and manufacturers do not discuss device failures with surgeons. The STAMP believes that some clinicians may not be aware of problems reported on surgical staplers and clip appliers and proposed to present information on about these devices through publications, Web sites, professional meetings, and FDA Advisory Panel meetings. The STAMP also plans to conduct a Rapid Response Survey to determine user awareness of device problems.

Vascular Hemostasis Devices - Hemostasis devices are used to seal off the femoral artery to prevent bleeding from the puncture site after a diagnostic or interventional cardiac catheterization. However, the most common adverse events associated with hemostasis devices involve bleeding, usually because of artery damage, often leading to surgical repair of the artery, and in some cases, resulting in death.

The FDA convened a workgroup to address an increase in the numbers of reports of deaths and serious injuries related to bleeding with these devices. The workgroup deliberations resulted in a "Dear Doctor" letter (October 1999) to alert healthcare practitioners to manufacturer warnings and instructions for patient selection and device use. Articles were published in *Nursing99* and the *International Journal of Trauma Nursing* (April-June 2000) to provide information about hemostasis device injuries and FDA's adverse event reporting system.

FDA's evaluation of reported hemostasis device adverse events also revealed that women have a much higher rate of adverse events. Preliminary results from a collaborative study with the American College of Cardiology show that women are at a much higher risk than men for hemorrhagic events associated with the use of hemostasis devices. These findings appear in *Pharmacoepidemiology and Drug Safety* January 2003.

Laparoscopic Trocar Injuries - FDA convened a Systematic Technology Assessment of Medical Product (STAMP) Committee to address the increasing numbers of reports of deaths and serious injuries related to the use of laparoscopic trocars (devices used to penetrate the abdomen and pelvis for insertion of laparoscopes and surgical instruments). Committee members included FDA staff and healthcare practitioners with expertise in health care, engineering, laparoscopic procedures and human factors. The committee completed the following activities:

- Reviewed and analyzed FDA adverse event surveillance data, trocar labeling, patient brochures on laparoscopic surgery;
- Reviewed FDA device recall data;
- Reviewed existing published literature;
- Published an article (ACOG Today, October 2002) to provide information about laparoscopic trocar injuries and FDA's adverse event reporting program. The committee will publish a summary of its findings by the end of 2003.

Investigation of 70 Patient Deaths from Chemically Contaminated Kidney Hemodialyzers

The coordinated efforts of a group of FDA/CDRH health officials, scientists, and engineers successfully resolved a public health crisis. In October 2001, CDRH received reports of several patient deaths at kidney hemodialysis facilities in the U.S. and many more deaths in Europe, Asia and South America. The common link proved to be three models of hemodialyzers manufactured by a U.S. based company at their European facility. FDA quickly developed and put into motion a strategy to determine the cause of the problem and prevent it from recurring. The manufacturer conducted a global recall of 2.4 million dialyzers. Analysis confirmed the presence of a chemical fluid contaminant (used during a

manufacturing step) in some of the recalled dialyzers; animal testing demonstrated its presence in the bloodstream can cause pulmonary distress and death by air embolism. CDRH contacted all other manufacturers of dialyzers to ensure that they were not using the chemical in their facilities. CDRH also believed it was likely that other closely related fluids could present a similar hazard. Therefore, CDRH mailed an advisory letter to consignees of the fluid manufacturer warning about the potential health hazards.

Medical Device Approvals:

Heart and Cardiovascular System

- November 19, 2002, FDA cleared the Elecsys proBNP Immunoassay test. This test is a first of a kind fully automated test for diagnosing congestive heart failure. The automation allows the laboratory to run a higher volume of samples, making the test more readily available to patients who need it. The Elecsys proBNP Immunoassay test, made by Roche Diagnostics, is run on the Roche Diagnostics Elecsys Analyzers. The test detects the level of a peptide, NT-proBNP, which issecreted almost exclusively by the heart. An elevated level can indicate the presence of congestive heart failure. The higher the blood levels of proBNP, the more serious the condition. The test can help doctors distinguish between congestive heart failure and other problems, such as lung disease. Early detection of congestive heart failure is important because, if detected early, it can often be managed with medication.

- FDA cleared two laboratory tests on September 30 and October 24, 2002, to measure the quantitative determination of prothrombin time in capillary whole blood by trained patients or their caregivers at home. These tests are used to monitor oral anti-coagulation therapy in patients receiving blood thinners such as Coumadin to prevent blood clots.

- On December 3, 2002, FDA cleared a high sensitivity CRP laboratory test kit to aid in the detection and evaluation of infection, tissue injury (such as heart tissue), inflammatory disorders and associated diseases.

- On August 28, 2001, the InSync® Biventricular Cardiac Pacing Systems was approved. It is used to relieve some symptoms of moderate to severe heart failure in patients who have an electrical disturbance in the heart, resulting in the ventricles not contracting at the same time. These patients are also not likely to improve with more drug therapy. Heart failure is a condition where the heart cannot adequately pump blood around the body and may result in shortness of breath or fatigue during exertion.

- June 2, 2001, the Percusurge Guardwire Plus, an embolic protection system, was cleared for market. It is used during interventional cardiology procedures. The device is intended for use on patients who have previously had coronary bypass surgery and whose bypass vein graft has become blocked. These blockages require treatment such as insertion of a stent during angioplasty, which opens a narrowed vessel. The PercuSurge device consists of a balloon catheter and aspiration catheter. The device is used during these procedures to collect and remove debris created by the interventional treatment by preventing blood clots from traveling into the bloodstream. The debris—small blood clots, cholesterol crystals, and other particles—may cause serious problem, such as heart attack, if it is swept down the vein graft into the heart.

- August 9, 2002, the Neurological Stent for Recurrent Intracranial Stroke - Neurolink® System, which consists of a Stent Delivery Catheter and a Balloon Dilatation Catheter, was approved. The Neurolink® System is intended to treat patients with recurrent intracranial stroke caused by

atherosclerotic disease. The device is a balloon expandable stainless steel mesh tube that is designed to open the target blood vessel and provide support. The device is intended for patients who have ≥ 50% stenosis in the target intracranial vessels, leading to reduced blood flow to the brain with accompanying neurological symptoms. The Balloon Dilatation Catheter allows the physician to open narrowed atherosclerotic areas in the blood vessel before placement with the stent. The Nurolink® System is the first device approved to treat these patients.

- On July 18, 2002, a new use was approved for the Ventak automatic implantable cardiac defibrillator, made by Guidant Corporation. It can now be used prophylactically in many people who have had a previous heart attack and an ejection fraction ≤ 30%. Ejection fraction is a measure of how efficiently the heart pumps blood. A level of 30% or less is an indicates impaired function that puts heart attack survivors at increased risk for sudden cardiac death. The expanded indication is based on results from the MADIT II trial. The trial showed that use of these devices reduced total mortality by 31% for heart attack survivors with compromised heart function.

- The Contak CD CRT-D was approved on May 2, 2002. It is a new type of implantable cardioverter defibrillator (ICD) that also has the ability to deliver cardiac resynchronization therapy. The device is the first of its kind to be used to treat symptoms of advanced heart failure in certain people who already need an ICD. The device combines an implantable cardiovert defibrillator with cardiac resynchronization therapy (CRT). The defibrillator component detects and treats life-threatening heart rhythms. The CRT component coordinates that beating of the left and right ventricles of the heart so they work together more effectively to pump blood throughout the body. The device is intended to treat people who already need an implantable defibrillator, whose heart timing is off and who, despite taking heart failure medication, have symptoms of advanced heart failure, such as fatigue, shortness of breath and difficulty performing daily activities.

- The wearable cardioverter defibrillator (WCD®) was approved on December 18, 2001, and is used by adult patients 24 hours a day to monitor and treat dangerous, abnormally fast heart rhythms. The abnormal rhythms lead to a complete absence of heart beat (sudden cardiac arrest) and death (sudden cardiac death) if they are not treated. The WCD is a combination of two different devices. As a cardiovert, it uses low-energy electrical shocks to return an abnormally fast heart beat (ventricular tachycardia or "VT" to a normal rhythm. As a defibrillator, it uses high-energy shocks to return a very fast, disordered heart beat (ventricular fibrillation or "VF" to a normal rhythm. The Wearable Cardiovert Defibrillator (WCD) dies the same job as an implantable cardioverter defibrillator (ICD). The difference is that the WCD is non-invasive, which means that it requires no surgery, implantation, or entry into the body. Instead, patients wear a vest-like garment that holds the WCD parts – a monitor, electrodes, and small "alarm module." The WCD is fully automatic and require any patient action to deliver treatment, but the patients are able to prevent treatment if it is not needed. The WCD® device is worn if a patient is at risk of sudden cardiac arrest and an implantable defibrillator is not wanted or is not practical.

Cancer

- On December127, 2002, FDA cleared the Bayer prostate specific antigen (PSA) assay for the Advia IMS system to aid in the management of prostate cancer patients.
- On December 17, 2002, FDA cleared the Bayer complexed PSA for Advia IMS to aid in the management of prostate cancer patients.
- On November 11, 2002, FDA cleared the Bayer CA125 for the Advia IMS to aid in the management of ovarian cancer.

- On December 11, 2002, FDA cleared the Beckman Coulter OV monitor (CA125) assay to aid in the management of ovarian caner patients.
- On December 18, 2002, FDA cleared the Tosoh AIA-Pack CEA assay to aid in the management of colorectal cancer patients in whom changing concentrations of CEA are observed.
- On December 23, 2002, FDA cleared the Tosoh AIA-Pack Ca19-9 laboratory test as an aid in the management of pancreatic cancer.

Immunology
- On November 25, 2002, FDA cleared the Hyperion Visiquant anti-nuclear antibody test to help diagnose auto-immune and connective tissue disease, such as systemic lupus erythematosus and Sjogren's Syndrome.
- On December 17, 2002, FDA cleared the Diagnostic Products Corp. Immulite 2000 allergen-specific IgE to help diagnose IgE-mediated allergic disorders.
- On October 9, 2002, FDA cleared the Diastat anticyclic citrullinated peptide laboratory test to help diagnose Rheumatoid Arthritis.

Vision
- The AquaFlow Collagen Glaucoma Drainage Device, approved on July 12, 2001, is used to treat open-angle glaucoma, a condition in which the intraocular pressure is abnormally high. If left untreated, glaucoma can cause blindness. The device is small cylinder made of collagen. Implanted in the eye, it helps lower the pressure by absorbing excess fluid. It is the first device approved for use when excess intraocular pressure cannot be completely controlled with medications. Previously cleared glaucoma devices are used only after medications, and trabeculectomy surgery has failed. Besides reducing intraocular pressure, it may allow patients to reduce the number of glaucoma medications they need to control their intraocular pressure.

Intraocular Lens - Approximately 1.5 million intraocular lenses (IOLs) are implanted each year in the United States alone, at an annual cost on the order of $6 billion. Most of these lenses are implanted because of age-related development of cataracts in the natural crystalline lens. Patients who receive IOLs experience a marked increase in visual acuity, thus significantly improving their independence and quality of life. New types of IOLs are being introduced into the marketplace, including, for example, accommodative, toric, and multifocal. Phakic IOLs are being developed to correct myopia and hyperopia in patients who are not satisfactory candidates for refractive surgery or who may be contact lens intolerant. Some new materials used in IOLs develop unwanted bubbles after implantation, which can significantly affect vision.

CDRH maintains laboratory instrumentation to evaluate the quality of intraocular lens implants. We are continuing to conduct research to determine appropriate device performance parameters and develop standardized test methods for safe and effective use of new types of intraocular lenses. CDRH is also continuing to participate in revision of the current standards to include requirements for new generations of IOLs. The standards will be used to expedite document reviews.

Diabetes
- On March 22, 2001, CDRH approved the GlucoWatch® Automatic Glucose Biographer from Cygnus, Inc., is the first glucose monitoring device that doesn't puncture the skin. Adult diabetics wear the device like a watch where a slight electric current pulls glucose through the skin. Glucose levels are automatically read and recorded every 20 minutes for up to 12 hours. Alarms warn users when high, low, or rapidly declining glucose levels occur. Readings are stored so users can retrieve them. Users can better manage their diabetes because they receive information about patterns in

their glucose levels. GlucoWatch® results may be similar to finger-stick test results taken at the same time, although some readings will differ significantly from finger-stick tests. GlucoWatch® does not replace finger-stick testing and is not for diabetics below the age of 18.

- On December 13, 2002, CDRH approved the Metrika, Inc., A1c Now for Home Use. This device provides a quantitative measurement of the percent of glycated hemoglobin levels in capillary blood samples. This test is used at home by patients that have diabetes to monitor long-term glycemic control.

Tuberculosis

- The QuantiFERON-TB was approved on November 28, 2001, and is the first in vitro test to detect cell-mediated immunity to Mycobacterium tuberculosis. The tuberculin skin test that has been used for over 50 years to detect cell-mediated immunity to M. tuberculosis in an in vivo test, requiring a repeat patient visit with 48-72 ours to read results. The QuantiFERON-TB assay on the other hand does not require a repeat visit to obtain results. It measures the release of IFN-g (gamma interferon) from lymphocyctes in a whole blood sample during an overnight incubation with mycobacterial (PPD) and control antigens. It is indicated for testing individuals who originate from an area where tuberculosis is prevalent, or who are at increased risk by occupation or setting (e.g., healthcare workers, prisons, injection drug users). The assay is also indicated for testing population groups wehre the consequences of active infectious teberculosis may be sever (military, healthcare workers, students at some institutions). Persons with a positive result may be at increased risk of subsequently developing active tuberculosis.

Hearing

- The SOUNDTEC® Direct implanted hearing device was approved on September 7, 2001, and is intended to help adults with moderate to severe nerve hearing loss. The implanted portion of the device is a tiny magnet attached to one of the middle ear bones. It converts sound to mechanical energy that is transferred to the middle ear much the way normal sound does. The brain interprets the vibrations as sound. This device is different from another implantable middle ear hearing device in that it is minimally invasive. The surgeon goes through the ear canal to place the implant in the middle ear. There are no external incisions. This device is an alternative to traditional hearing aids. Adults who choose this device should have already tried traditional hearing aids and not been satisfied with them.

- The RetroX Transcutaneous Air Conduction Hearing Aid System was approved on August 20, 2002, and is a new type of hearing aid that works without plugging the ear canal. This hearing aid sends sound through a tube that a doctor has inserted through soft tissue between the back of the outer ear and the outer ear canal. It is used anytime the user wants to improve hearing. It should not be used if there is local inflammation or infection in the skin behind the ear or if there is injury to the ear that would make placement of the tube impossible.

Pneumonia

- Two laboratory tests for detecting Influenza A and B were cleared on September 19, 2002, and one on November 30, 2001. Influenza viruses cause the most serious acute respiratory illnesses, typically the flu and pneumonia. During recent decades, influenza and pneumonia death has increased among the elderly.
- Two laboratory tests for screening for respiratory viruses were cleared, one on October 6, 2002, and the other on December 18, 2002. These tests contained reagents to screen for the common respiratory viruses (i.e. Respiratory Synctial Virus, Influenza A and B, Adenovirus, Parainfluenza 1 and 2). Respiratory viruses cause a respiratory tract infection, which may lead to pneumonia.

Respiratory viruses accounts for great morbidity and mortality among the elderly whom are at high risk

Research:

Ultrasound and the Diagnosis of Osteoporosis - Older Americans have higher risk for osteoporosis than younger Americans. With the aging of the baby boom generation and the advent of many new pharmaceutical treatments for osteoporosis in the last decade, there is now an increased demand for improved diagnostic techniques. Ultrasound offers an effective, inexpensive, small, portable, easy-to-use and non-ionizing alternative to traditional x-ray techniques. FDA scientists have developed innovative methods (based on ultrasonic backscatter) for noninvasive assessment of bone. Basic theoretical modeling and experiments conducted by FDA scientists have revealed basic mechanisms underlying the interaction between ultrasound and bone. This information is critical in designing and developing new ultrasound devices to diagnose osteoporosis.

Transmyocardial Revascularization Study - In collaboration with the Society of Thoracic Surgeons, FDA conducted a study of mortality and morbidity of transmyocardial revascularization (TMR), including over 3,000 patient procedures. TMR procedures are performed to relieve angina pectoris. The mean age of TMR only recipients was 62 years old compared to a mean age of 65 years old for patients who received TMR and coronary artery bypass. The overall mortality rate for patients who received only TMR was 6.4%. Statistical analysis demonstrated that TMR risks were significantly higher in patients with recent myocardial infarction, unstable angina and depressed ventricular function. Being a woman was not a risk factor for mortality or major morbidity following TMR procedures.

Postmarket Assessment of Hemostasis Devices - The Epidemiology Branch analyzed data from the American College of Cardiology's National Cardiovascular Data Registry, to assess the relative risks of severe complications associated with hemostasis devices, which are used to stop femoral artery bleeding following the procedure. The main findings from over 150,000 cardiac catheterizations were the following. Women exhibited approximately twice the incidence of men for every complication of hemostasis devices that was examined, including death. Overall, the hemostasis devices were associated with a lower incidence of serious injuries than were controls (i.e., those for whom manual compression was used to stop bleeding from the femoral artery following cardiac catheterization). This was especially true of the collagen plug type hemostasis devices, which exhibited less than 80% of the complication rate experienced by controls.

Gender and Sex Hormones Alter the Response of Coronary Arteries to Angioplasty - The risk of cardiovascular death in women increases after menopause. Before menopause, women have a lower incidence of cardiovascular disease than men of all ages; this advantage is lost after menopause. FDA scientists have established an animal model (swine) to study the effects of gender and hormone status on stenosis (narrowing of the artery) of coronary arteries following balloon angioplasty. The research has modeled the effects of menopause on the female's response to angioplasty, showing that the swine gender model and the human respond similarly, with the gonad-intact male having five times more stenosis (coronary arterial narrowing) than the ovulating female (pre-menopausal model). As observed in women, this advantage was lost when the pig's ovaries were removed (menopausal model). This model allows FDA scientists to study the mechanisms behind these gender- and hormone-specific differences in response to angioplasty and their effect on the safety and effectiveness of interventional therapies for cardiovascular disease.

Impact of Age on the Response of Coronary Arteries to Angioplasty - Young animals are used as models in most pre-clinical trials. Since the wound healing response of the young animal is better than that of

the older animal, FDA scientists are examining the effect of age within the swine cardiovascular injury models established during earlier studies. The FDA scientists are comparing the responses of younger and older pigs in their balloon angioplasty model. They will be examining how the maturity of the animal affects tissue repair of vascular injury and stenosis (narrowing of the artery) of coronary arteries in response to balloon angioplasty and how this impacts on device safety and effectiveness.

Standards Development - Scientists actively participate in national and international standards activities involving the safety and efficacy of medical devices, many of which are of interest to older Americans. These standards include the biological evaluation and testing of medical devices, test methods ensuring that the materials used in those devices are safe for the intended use, and test methods assuring that the devices are clean and sterile. These consensus standards have input from manufacturers, academia, and regulatory agencies.

Web site
CDRH's Web site (www.fda.gov/cdrh) provides links to consumer information on many topics of interest to older Americans. CDRH developed or maintained the following Web sites in 2001 and 2002:

- Newly approved medical devices (http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cftopic/mda/mda-list.cfm?list=1)
- Mammography (http://www.fda.gov/cdrh/mammography/index.html)
- CT Whole Body Scanning (http://www.fda.gov/cdrh/ct)
- Diabetes (www.fda.gov/diabetes)
- Lasik Surgery (http://www.fda.gov/cdrh/lasik/)
- Cell Phones (http://www.fda.gov/cellphones/)
- Buying a Medical Device Online (http://www.fda.gov/cdrh/consumer/choosing.html#2)
- Breast Implants (http://www.fda.gov/cdrh/breastimplants/)

Publications
- *Journal of General Internal Medicine* (Barton MB, Moore S, Shtatland E, Bright RA 2001;16(3):200-3. "The relation of household income to mammography utilization in a prepaid health care system"

- *Epidemiology,* 2002 (Vol. 3) edited a special issue devoted to the proceedings of the Conference on Epidemiology of Medical Devices in Women. The issue included some presentations and interesting topics to the aging populations included coronary interventions, osteoporosis, and cervical cancer screening.

CDRH–FDA & HHS Press Releases, Fact Sheets, Public Health Notifications and Statements Related to Older Americans
- Complications Related to the Use of Bone Cement in Treating Compression Fractures of the Spine – 10/31/2002 updated 4/1/2003
- Diathermy Interactions with Implanted Leads and Implanted Systems and Leads – 12/19/2002
- Reducing Radiation Risk from Computed Tomography for Pediatric and Small Adult Patients – 11/2/2001
- Potential for Injury from Medical Gas Misconnections of Cryogenic Vessels 0 7/20/2001
- Problems with Endovascular Grafts for Treatment of Abdominal Aortic Aneurysm (AAA) – 4/27/2001
- Lead Exposure from Dental Films Stored in Lead-Lined Table-top Containers – 3/13/2001

CENTER FOR BIOLOGICS EVALUATION AND RESEARCH (CBER)

Office of Biostatistics and Epidemiology

Vaccine Safety: The Vaccine Safety Branch (VSB) monitors reports of adverse events after vaccination in all age groups, including the elderly, through the Vaccine Adverse Event Reporting System (VAERS). Flu and pneumococcal vaccines are targeted for use in the elderly, and the safety of these vaccines is of special interest in this age group. Besides VAERS surveillance, the VSB is conducting special studies of flu and pneumococcal vaccine safety in the elderly using the Medicare system.

Office of Blood Research and Review

1. HIV: One of the faster-growing groups of HIV-infected people is the elderly. With women outnumbering men in retirement communities, the men tend to have multiple sexual partners. Any one infected person in a community of elderly people thus can cause the rapid spread to others. At a recent CDC-sponsored meeting, it was urged that the elderly as a group that should be targeted for attention regarding HIV prevention.

CBER recently approved rapid tests for screening for HIV. These tests will make it easier for the elderly to be tested for HIV in one short visit to their doctor or health facility. In the past, two visits were required - one to provide a test specimen and the other to receive the test result, often a week apart because of limitations of the testing technology. In association with the recent approval of an HIV rapid test, the approved test was designated a "waived test" under CLIA regulations, making it more generally available and more accessible. (The waiver was handled by CDRH and CMS, but that couldn't have happened without the CBER approval.)

2. West Nile Virus (WNV): Of the 23 patients who acquired transfusion-transmitted WNV during 2002, 8 (35%) were over age 70. Thus, elderly patients are unusually susceptible to transfusion transmitted WNV infection.

CBER has worked with other organizations to develop contingency plans for safe blood for transfusion and to prepare for the next year's epidemic. CBER held a workshop to encourage test manufacturers to develop screening assays for WNV, expedited review and approval of three applications to implement nationwide blood donor screening (which found 600 contaminated units), and developed standard reagents to monitor test sensitivity.

Office of Cellular, Tissue and Gene Therapies

Unmet Medical Need for the Aging Population: Interstitial Pneumonias and Pulmonary Fibrosis: As the U.S. population ages, the incidence of idiopathic interstitial pneumonias (IIP) and consequent pulmonary fibrosis is on the rise. Factors that cause and maintain this debilitating disease in chronic state are poorly recognized. CBER scientists are conducting collaborative studies with scientists from the University of Michigan to explore pathophysiology and develop mechanisms of targeting and eliminating terminal diseased cells responsible to maintain chronic stage of this disease.

Office of Vaccines Research and Review

New Vaccines and Vaccine Indications: Invasive Group B streptococcal disease (GBS disease) in adults with significant underlying conditions, such as diabetes, neurological impairment, end-stage

renal disease and cirrhosis results in significant morbidity and mortality. Adults over the age of 65 are at the highest risk of dying from invasive GBS disease, and this population should benefit from a GBS vaccine. Such vaccines are under development.

Significant morbidity and mortality have accompanied pneumococcal infections in the elderly, and this is the basis for the current recommendation for immunization with the 23-valent pneumococcal polysaccharide vaccine. New immunization strategies against pneumococcal disease in the elderly are being developed, including the potential use of the recently licensed pneumococcal polysaccharide-protein conjugate vaccine (this vaccine is licensed for a pediatric population).

Shingles is a debilitating condition stemming from the re-emergence of the varicella virus (the virus that causes chicken pox) from its latent state. The incidence and severity of shingles increases with increasing age. The use of the currently licensed varicella vaccine (which has a pediatric indication) is being studied as a measure to prevent shingles in the elderly.

Current vaccines: The morbidity and mortality that accompanies influenza virus infections increases significantly with increasing age. Routine immunization against the flu is recommended for all adults over the age of 50. In recent years, for various reasons, there have been shortages and delays in marketing influenza vaccine. FDA has been working diligently with manufacturers to help ensure the timely marketing of sufficient quantities of vaccine for all needed populations.

As noted above, the 23-valent pneumococcal polysaccharide vaccine is recommended for the elderly. This vaccine has been available for over 20 years, although its use has been less than desired.

CENTER FOR DRUG EVALUATION AND RESEARCH

The mission of FDA's Center for Drug Evaluation and Research (CDER) is to promote and protect the public health by helping to ensure that safe and effective drugs are available to the American public including older Americans. FDA is continuing to make drugs safer for older Americans, who consume most of the nation's medications. Adults over the age of 65 buy 30 percent of all prescription drugs and 40 percent of all over-the-counter (OTC) drugs.
Public Participation

- Public Participation

CDER continues to maintain its long-standing tradition of involving the public in its activities. In May 2002, CDER held a public hearing as part of the agency's efforts to improve CDER's risk communication and develop new and effective risk management tools. Although not specific to older patients, the communication and management of risk is important in all populations.

- OTC Labeling Changes Campaign

Effective May 2002, the FDA delayed the compliance dates for certain products subject to its final rule that standardized format and content requirements for labeling over-the-counter (OTC) drug products (Drug Facts Rule). That final rule requires all OTC drug products to comply with new format and labeling requirements within prescribed implementation periods. The agency intends to propose an amendment to the Drug Facts Rule to change the labeling requirements for "convenience-size'" OTC drug products. This final rule postpones the compliance dates under the Drug Facts Rule for certain convenience-size OTC drug products pending the outcome of the future rulemaking.

- Materials, Outreach, and Exhibits

The FDA continually strives to establish a dialogue between the agency and its constituents on important public health problems and issues. In addition, the agency actively participates in outreach activities with the National Patient Safety Foundation to address the safe use of medical products from the consumer and patient perspectives.

CDER has prepared several brochures specifically for older Americans. Titles include: "AgePage, Medicines: Use Them Safely," "Reducing Your Risk of Heart Attack or Stroke with Aspirin Therapy: Know the Facts," and "Be an Active Member of Your Health Care Team." There are many articles on the CDER Web site for consumer education, including drug interactions information, managing the benefits and risks of medicines, buying medicines, over-the-counter drug products, and generic drug products. This can be found at http://www.fda.gov/cder/consumerinfo/DPAdefault.htm.

- Postmarket Drug Surveillance and Epidemiology

CER's Office of Postmarketing Drug Risk Assessment is responsible for receiving, entering into a database, and analyzing reports sent to the agency on adverse reactions to drugs. In 2001, there were approximately 286,000 reports received to CDER's Adverse Events Reporting System. For 2002, the estimated number increased to 320,000 reports. Reports representing patients aged 65 years or older numbered 54,000 (19% of total for 2001) and 49,000 (15% of total for 2002). These percentages are similar to those reported in the past.

- Geriatric Labeling

In a final rule of August 27, 1997, FDA established the Geriatric Use subsection in the labeling for prescription drugs and biologics to information about the use of those products in the elderly. In October 2001 the agency finalized a guidance for industry on submitting geriatric labeling of human prescription

drugs and biologics. Concerning geriatric labeling, this guidance discusses who should submit revised labeling, implementation dates, optional standard language in proposed labeling, content and format for geriatric labeling; and applicability of user fees to geriatric labeling supplements.

- Generic Drugs

During Fiscal Year 2003, FDA's Office of Generic Drugs fully approved 284 abbreviated new drug applications. These drug products are often substantially less expensive and provide a safe and effective alternative to brand-name products. Many of these approvals represent the first time a generic drug of special interest to older Americans was made available. These include gabapentin to treat seizure disorders, loratidine to relieve symptoms of seasonal allergies, and omeprazole to treat ulcers and symptoms of other gastrointestinal disorders. These and other recently approved generic drug products could save the American public and federal government millions of dollars.

CENTER FOR FOOD SAFETY AND APPLIED NUTRITION (CFSAN)

Nutrition, Health Claims, and Labeling

- Nutrient Content Claim for Choline – On May 1, 2001 Central Soya submitted a nutrient content claim notification under the FDAMA. The notification was based on the Institute of Medicine's determination that the adequate intake of choline is 550 mg a day. FDA issued a letter of response on August 30, 2001 stating that manufacturers may use nutrient content claims for choline on the label and in labeling of foods or dietary supplements. One example of a nutrient content claim describing the level of choline in a food product is "Good source of choline. Contains 55 mg of choline per serving, which is 10% of the Daily Value for choline (550 mg)."
- Health Claims for Vitamin E and Heart Disease - On February 9, 2001 FDA issued a final determination on the scientific evidence supporting proposed health claims concerning vitamin E and reduced risk of coronary heart disease. FDA determined that health claims relating vitamin E supplements and reduced risk of cardiovascular disease are inherently misleading and cannot be made non-misleading with a disclaimer or other qualifying language, FDA did not permit the use of this claim.
- Health Claims for Soluble Fiber from Certain Foods and Coronary Heart Disease – In response to a health claim petition submitted by Quaker Oats Co. and Rhodia Inc. FDA published an interim final rule amending the health claim for β-glucan soluble fiber from certain foods and reduced risk of coronary heart disease to include oatrim (67 FR 61773; October 2, 2002). Oatrim is the soluble fraction of α-amylase hydrolyzed oat bran or oat flour that when added to foods such as yogurt, waffles, spaghetti sauce or fruit juices, helps lower cholesterol and thus the risk of coronary heart disease.
- Health Claims for D-tagatose – In response to a petition submitted by Arla Foods Ingredients, FDA published an interim final rule to amend the health claim for dietary sugar alcohols and dental caries (i.e., tooth decay) to include the sugar D-tagatose as a substance eligible for the claim (67 FR 71461; December 2, 2002). Products that replace other sugars with D-tagatose can help reduce the risk of tooth decay
- Qualified Health Claims for Omega-3 Fatty Acids and Heart Disease – On February 8, 2002, FDA issued a letter clarifying the language that could be used for a qualified health claim about the relationship between omega-3 fatty acids from dietary supplements containing EPA and DHA and reduced risk of heart disease. FDA concluded that the following statement about the relationship would properly qualify the state of the scientific evidence: "Consumption of omega-3 fatty acids may reduce the risk of coronary heart disease. FDA evaluated the data and determined that,

although there is scientific evidence supporting the claim, the evidence is not conclusive."

- Qualified Health Claims for B Vitamins and Vascular Disease - On May 15, 2002 FDA issued a letter clarifying the qualified health claim for dietary supplements containing folic acid or vitamin B_6, and vitamin B_{12} and heart disease. FDA concluded that the following statement and disclaimer would be appropriate in labeling: "As part of a well-balanced diet that is low in saturated fat and cholesterol, folic acid, vitamin B_6 and vitamin B_{12} may reduce the risk of vascular disease. FDA found that, while it is known that diets low in saturated fat and cholesterol reduce the risk of heart disease and other vascular diseases, the evidence in support of the above claim is inconclusive."
- Qualified Health Claims - On December 18, 2002 FDA published a guidance document entitled, "Qualified Health Claims in the Labeling of Conventional Foods and Dietary Supplements." FDA took this action to inform interested persons on the circumstances under which the agency intends to consider exercising its enforcement discretion to permit qualified health claims for conventional foods and dietary supplements. The guidance describes the process that FDA intends to use to respond to future health claim petitions, and clarifies that when the agency is evaluating food-labeling claims it will apply the "reasonable consumer" standard.
- Dietary Supplement Strategic Plan – Congress asked FDA to analyze the cost to implement the 10-Year Dietary Supplement Strategy. The agency predicts that the program can be implemented within 5 years for approximately $40-65 million and 133-244 Full Time Equivalents in the field and headquarters.
- Dietary Supplements – FDA developed a public/private coalition to address dietary supplement information designed for older Americans and how they can work with their health care team. The coalition is comprised of organizations directly involved with the elderly (e.g., Administration on Aging and AARP).
- Food Allergens – On August 13, 2001, a public meeting was held to help FDA determine what additional actions may be necessary to provide consumers with adequate information on product labels.

CFSAN – FDA & HHS Press Releases, Talk Papers, Fact Sheets and Statements
1/19/01 – FDA Issues Final Rule for the Safe and Sanitary Processing and Importing of Juice
4/11/01 - FDA Concerned About Botanical Products, Including Dietary Supplements Containing Aristolochic Acid
7/6/01 - FDA Advises Dietary Supplement Manufacturers to Remove Comfrey Products from the Market
11/7/01 - Dietary Supplements Claiming to Prevent or Treat Anthrax
11/19/01 - FDA Warns Consumers Not to Use the Dietary Supplement LipoKinetix
11/19/01 - Letter to Health Care Professionals on Hazardous Dietary Supplement Lipokinetix
11/19/01 - Letter to Distributor on Hazardous Dietary Supplement LipoKinetix
12/19/01 - Letter to Health Care Professionals about FDA Seeking Information on Liver Injury and Kava Products
2/8/02 - MedWatch Safety Alert: Consumers Warned to Stop Using the Dietary Supplement/Herbal Products PC SPES and SPES
3/25/02 - Consumer Advisory: Kava-Containing Dietary Supplements May be Associated with Severe Liver Injury
3/25/02 - Letter to Health Care Professionals: FDA Issues Consumer Advisory That Kava Products May be Associated with Severe Liver Injury
8/13/02 – FDA Warns Public About Chinese Diet Pills Containing Fenfluramine

11/29/02 - Hepatic Toxicity Possibly Associated with Kava-Containing Products (CDC MMWR Report
12/18/02 - FDA announced a major new initiative, "Consumer Health Information for Better Nutrition," to make available more and better information about foods and dietary supplements to help American consumers prevent diseases and improve their health by making sound dietary decisions.

Web site & Electronic Communication
CFSAN's dietary supplement Web site added a Web page, "Tips for the Savvy Supplement User: Making Informed Decisions and Evaluating Information," to help consumers evaluate and understand the diverse information and issues on dietary supplements. Additionally on the Food Labeling and Nutrition Web site, a Food Label Quiz was designed to assist consumers to learn about the information on the food label.

FDA launched The Dietary Supplements/Food Labeling Electronic Newsletter to provide interested parties access to key information and updates on dietary supplements, food labeling, and nutrition.

CENTER FOR VETERINARY MEDICINE

The FDA's Center for Veterinary Medicine (CVM) regulates the manufacture and distribution of food additives and drugs that will be given to animals. These include animals for human consumption as well as food additives and drugs for pet (or companion) animals. CVM is responsible for regulating drugs, devices, and food additives given to, or used on, over one hundred million companion animals, plus millions of poultry, cattle, swine, sheep, and minor animal species. (Minor animal species include animals other than cattle, swine, chicken, turkeys, horses, dogs, and cats.)

CVM's activities to evaluate drugs intended for food-producing animals ensure that food derived from these animals is safe for human consumption. This evaluation considers the safety of residues of antimicrobial drugs used in food-producing animals, given their potential to produce antimicrobial resistance in bacteria that may infect humans who consume improperly prepared food from these animals.

CVM's activities related to food safety are intended to benefit all Americans, including older Americans. Older Americans may derive special benefit from CVM's food safety activities because they have greater susceptibility to food-borne diseases.

The Center also works closely with other federal, state, and local authorities and with regulatory agencies abroad to coordinate efforts to protect the food and drug supply and to respond rapidly to evidence of threats.

HEALTH RESOURCES SERVICES ADMINISTRATION

This report provides information on current strategies, initiatives, and programs currently administered by HRSA, in our attempt to help our nation's older Americans.

The report also addresses geriatric education which is promoted in the Bureau of Health Professions; as well as the Bureau of Primary Health Care's initiative to increase access to comprehensive primary health care for elderly underserved patients. The Office of Rural Health Policy which supports aging-related issues, usually rural areas have on an average, a higher percentage of individuals over 65 years of age; the Center for Health Services Financing and Managed Care which collaborates with other Federal agencies and assists in workshops where the public is queried for information and advice on a range of rural health needs. The HIV/AIDS Bureau has projected that eleven percent of all newly diagnosed cases of AIDS is in persons 50 years and older and this bureau is conducting a research study that examines variations in service use and intensity by age to better understand the potential increased demand for medical care and other services.

BUREAU OF HEALTH PROFESSIONS

The mission of the Bureau of Health Professions (BHPr) is to improve the health status of the population by providing national leadership in the development, distribution and retention of a diverse, culturally competent health workforce that provides the highest quality of care for all. The Bureau seeks to assure the appropriate supply, diversity, composition and distribution of the health professions workforce; assure the availability and equitable distribution of a full range of health workforce services and skills nationwide; promote excellence in health professions education and practice; and strengthen the infrastructure to support an efficient and effective health professions workforce.

Additionally, the Bureau has an initiative in geriatric education which is promoted throughout the Bureau's training programs. The Bureau's initiative in geriatrics emphasizes faculty development, increasing the number of geriatric health care providers, integrating geriatric content into health professions curriculum, and providing continuing education offerings in geriatrics to all health professionals to promote access to quality geriatric health care and services. The geriatric emphasis will help ensure that health care workers are trained and become knowledgeable about the aging process, diseases and common conditions of the elderly, and older people's special problems and needs.

The strategies defined by these functions and areas of emphasis are implemented through a variety of collaborative public and private efforts and programs supported and operated by the Bureau. Programs include: education and training grant programs for institutions such as health professions schools and health professions education and training centers; loan and scholarship programs for individuals, particularly those from disadvantaged backgrounds; the National Practitioner Data Bank; the Healthcare Integrity and Protection Data Bank; and the Children's Hospitals Graduate Medical Education Program. In addition, BHPr administers several education-service network multidisciplinary and inter-disciplinary programs such as the Area Health Education Centers (AHECs) Program, the Geriatric Education Centers (GECs) Program, and the Quentin N. Burdick Program for Rural Interdisciplinary Training.

The multi- and inter-disciplinary programs:

- Train health professional to deliver cost-effective, high-quality health care in medically underserved areas;
- Stimulate curricula improvements so that health education reflects the needs of vulnerable populations and changes in health care financing; and
- Improve racial and cultural diversity in the health professions, which results in greater access to health care by minority and lower-income Americans.

The Bureau also supports the Council on Graduate Medical Education, which reports to the Secretary and the Congress on matters related to graduate medical education, including the supply and distribution of physicians, shortages, or excesses in medical and surgical specialties and subspecialties, foreign medical graduates, financing medical educational programs, and changes in types of programs. It also supports the National Advisory Council on Nurse Education and Practice which provides advice and recommendations to the Secretary concerning

policy matters relating to nurse workforce, education, and practice improvement. In addition, the Bureau supports the National Advisory Committee on Interdisciplinary, Community-Based Linkages which provides advice and recommendations to the Secretary and the Congress on interdisciplinary, community-based health professions education policy and program development.

BHPr maintains a federally sponsored health practitioner data bank on all disciplinary action and malpractice claims. The National Practitioner Data Bank (NPDB) was created by The Health Care Quality Improvement Act of 1986, Title IV of P.L. 99-660, as amended November 1986. The Act authorized the Secretary of Health and Human Services to establish a data bank to ensure that unethical or incompetent medical and dental practitioners do not compromise health care quality. The NPDB is a central repository of information about: malpractice payments made on behalf of physicians, dentists, and other licensed health care practitioners; licensure disciplinary actions taken by State medical boards and State boards of dentistry against physicians and dentists; and adverse professional review actions taken against physicians, dentists, and certain other licensed health care practitioners by hospitals and other health care entities, including health maintenance organizations, group practices, and professional societies. The NPDB began operation on September 1, 1990.

The Secretary of the U.S. Department of Health and Human Services, acting through the Office of Inspector General was directed by the Health Insurance Portability and Accountability Act of 1996 to create the Healthcare Integrity and Protection Data Bank (HIPDB). The HIPDB is a national health care fraud and abuse data collection program for the reporting and disclosure of certain final adverse actions taken against health care providers, suppliers and practitioners. Health plans and Federal and State programs and officials (including licensing agencies, certification agencies, criminal prosecutors, government attorneys participating in civil cases, and agencies taking program exclusion actions) are required to report to the data bank all final adverse actions (such as revocations, suspensions, exclusions, criminal convictions and civil judgments) against health care providers, suppliers and practitioners. Federal and State agencies and health plans are permitted to query the data bank. It began full operation on March 2000.

The Children's Hospitals Graduate Medical Education Program provides a more adequate level of support for health professions training in U.S. children's teaching hospitals that have a separate Medicare provider number ("free-standing" children's hospitals). These hospitals receive very small amounts of from Medicare for graduate medical education (GME) and other health professions training, while children's hospitals that share Medicare provider numbers with other teaching hospitals receive more typical amounts of GME from Medicare. As managed care organizations become increasingly unwilling to pay for GME, free-standing children's teaching hospitals are at a competitive disadvantage, in the absence of a similar level of support from Medicare that other hospitals receive, and are coming under increasing pressure to reduce their level of residency training. Children's hospitals train over 25 percent of all U.S. general pediatric residents, the majority of pediatric subspecialty residents, and about 4 percent of all medical residents. The goal of this program is to make the level of Federal GME support more consistent with other teaching hospitals, including children's hospitals which share Medicare provider numbers with other teaching hospitals.

DIVISION OF MEDICINE AND DENTISTRY

The Division of Medicine and Dentistry (DMD) continues to support, through its grant and cooperative agreement programs, significant educational and training initiatives in geriatrics. The Training in Primary Care Medicine and Dentistry grant program supports geriatrics curriculum development, implementation, and evaluation for physicians in primary care (family medicine, general internal, and general pediatrics), physician assistants in primary care and general and pediatric dentists. Support is provided to conduct activities at the following levels - medical school, residency training, faculty development, and physician assistant program.

At the predoctoral medicine level grantees indicated that they were actively involved in the development, implementation, and evaluation of their geriatrics curriculum and training. .

Residency program grants were awarded with a focus on geriatrics, emphasizing the interdisciplinary approach, home visits, and nursing home visits.

Faculty development programs instituted training activities, enhanced primary care research training, and developed strategies for career development in geriatrics. These programs also placed an emphasis on the instruction of, "Teaching Geriatrics."

The majority of academic administrative units developed a research infrastructure in support of primary care research with an emphasis on the elderly, palliative care, and geriatric education.

Physician assistant training program grantees continued the development of geriatrics curricula.

Podiatric primary care residency programs supported training which emphasized geriatric health.

Title VII funded training programs in the general and pediatric practice of dentistry provide a favorable Special Consideration for applicants that propose to prepare practitioners to care for underserved populations and high risk groups such as the elderly and patients of long term care facilities. In addition, applicants may also propose innovative projects that encourage curriculum enrichment or unique resident experiences in the area of geriatric dentistry.

The Society of Teachers of Family Medicine (STFM) was awarded a four-year contract to develop a faculty resource manual to assist medical school faculty with the inclusion of geriatrics into the curriculum for medical students over the entire four years of medical school. This project will define new competencies for medical students that also include palliative and end-of-life care. This grantee received approximately $25,000 for geriatric activities.

In FY 2002, the Division of Medicine and Dentistry grants with a primary focus on geriatrics totaled $325,430. In FY 2003, the Division of Medicine and Dentistry grants with a primary focus on geriatrics totaled $1,254,178.

DIVISION OF NURSING

HRSA administers programs authorized under Title VIII of the Public Health Service Act. Title VIII was amended by the Health Professions Education Partnerships Act of 1998 (P.L. 105-392 and the Nurse Reinvestment Act (NRA) of 2002 (P.L. 107-205).

Title VIII programs are primarily administered by the HRSA Bureau of Health Professions' Division of Nursing. Specific activities helping to mitigate the shortage of nurses include support for (1) basic and advanced nursing education programs, (2) diversity programs targeting minority and disadvantaged students, (3) scholarship, traineeships and loans, (4) retention programs, and (5) nursing workforce analysis.

- In FY 2003, $113.5 million is available for Title VIII programs. Of this, $50.5 million is provided for *Advanced Education Nursing*; $10 million for *Nursing Workforce Diversity*; $27 million for *Nurse Education, Practice and Retention*; $20 million is provided for the *Loan Repayment and Scholarship Programs* ($15 million for the *Nurse Education Loan Repayment Program* and $5 million for the new *Nurse Scholarship Program* added by the NRA); $3 million for *Nurse Faculty Loan*; and $3 million for *Comprehensive Geriatric Education*.

  The *Advanced Education Nursing Program* supports projects educating nurses for faculty positions in nursing schools, public health nurses, nurse administrators and advanced practice nurses which include nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives. Funds from this program support advanced education projects enrolling approximately 3500 students and provides traineeship support for 6800 graduate level students.

  The *Nursing Workforce Diversity Program* provides support to projects targeting 1800 minority and disadvantaged students in elementary and secondary schools, pre-nursing programs, and nursing schools. This program provides remedial and support services necessary to assure successful completion of those students enrolled in nursing programs.

  The *Nurse Education, Practice and Retention Program* is a broad authority with targeted purposes under three priority areas - education, practice and retention - in response to the growing nursing shortage. The *Nurse Education and Practice Program* supports academic and continuing education projects designed to recruit and retain a strong nursing workforce.

  Specific purposes identified under the *Education Priority Area* include:
  (1) expanding enrollment in baccalaureate nursing programs to increase the number of registered nurses;
  (2) developing and implementing internship and residency programs with mentoring components designed to retain new nurses, bring nurses back into the workforce and support the development of specialties for experienced nurses; and
  (3) providing education in new technologies, including distance learning methodologies.

Specific purposes identified under the *Practice Priority Area* include:
(1) establishing or expanding nursing practice arrangements, commonly referred to as nurse managed centers, in non-institutional settings to demonstrate methods to improve access to primary health care in medically underserved communities;
(2) providing care for underserved populations and other high risk groups such as the elderly, individuals with HIV/AIDS, substance abusers, the homeless, and victims of domestic violence;
(3) providing managed care, quality improvement, and other skills needed to practice in existing and emerging organized health care systems; and
(4) developing cultural competencies among nurses.

Specific purposes identified under the *Retention Priority Area* include:
(1) career ladder programs to promote advancement in a variety of training settings and assisting individuals in obtaining education and training required to enter the nursing profession; and
(2) projects to improve the retention of nurses and enhance patient care that is directly related to nursing activities.

The *Nursing Education Loan Repayment Program* assists registered nurses by repaying up to 85 percent of their qualified educational loans over 3 years in return for their commitment to provided services at health facilities with a critical shortage of nurses.

The *Nurse Scholarship Program* provides financial aid to nursing students in return for a working a minimum of 2 years in a health care facility with a critical shortage of nurses.

The *Comprehensive Geriatric Education Grant Program* focuses on training, curriculum development, faculty development, and continuing education for nursing personnel.

The *Nurse Faculty Loan Program* is designed to increase the number of qualified nursing faculty by providing a cancellation provision in which 85 percent of the loan may be cancelled over 4 years in return for serving full-time as faculty in a school of nursing.

DIVISION OF STATE, COMMUNITY, AND PUBLIC HEALTH

The Division of State, Community, and Public Health (DSCPH) seeks to support a health professions workforce that practices interdisciplinary quality health care; has skills to respond to emerging health issues; fills the needs of health professional shortage areas; and receives training and education through community-based sites and through computer-based technologies. Supported programs include Area Health Education Centers, Health Education and Training Centers, Education and Training Related to Geriatrics, Rural Interdisciplinary Training Grants, and Allied Health Project Grants. The Division also administers the State Loan Repayment Program.

DSCPH supports the training of health professionals in geriatric care though three principal programs--Geriatric Education Centers; Faculty Training in Geriatrics for Physicians, Dentists, and Behavioral and Mental Health Professionals; and Geriatric Academic Career Awards. Authorized by the Public Health Service Act, as amended, Sections 753 (a), (b), and (c) respectively, these three programs focus on preparing the health care workforce to serve an aging population. The AHEC program supports continuing education in geriatrics. The Quentin R. Burdick Rural Interdisciplinary Training program promotes rural health care practice which may include geriatrics. The Allied Health Project Grants may also address geriatrics.

GERIATRIC EDUCATION CENTERS PROGRAM

Geriatric Education Center (GEC) grants are made to accredited health professions schools, programs that train physician assistants and schools of allied health. Since 1985, 375,000 health professionals have received training in geriatrics through the Centers. Geriatric Education Centers:

- Improve the training of health professionals in geriatrics
- Provide geriatric residencies, traineeships and fellowships
- Develop and disseminate curricula on the treatment of health problems in elderly individuals
- Train and re-train faculty to provide instruction in geriatrics
- Support continuing education for health professionals who provide geriatric care
- Provide clinical geriatrics training in nursing homes, chronic and acute care hospitals, ambulatory care centers and senior centers

Geriatric Education Centers provide services to and foster collaborative relationships among health professions educators (organizations and institutions that sponsor formal and informal educational programs and activities for faculty, students and practitioners) within defined geographic areas (states, counties, metropolitan areas or portions thereof). Geriatric Education Centers strengthen multidisciplinary training of health professionals to diagnose, treat and prevent disease and other health problems that older people face.

Projects must involve at least four health disciplines, one of which must be medicine. These Centers are educational resources providing multidisciplinary and interdisciplinary geriatric training for health professions faculty, students, and professionals in medicine, dentistry, pharmacy, nursing, occupational and physical therapy, podiatric medicine, optometry, social work, and related allied and public or community health disciplines. They provide comprehensive services to the health professions education community within designated geographic areas. Grants may support geriatric residencies, traineeships or fellowships; development and dissemination of curricula; training and retraining of faculty; continuing education of health professionals; and clinical training in geriatrics in various care settings. Grantees may be single institutions or consortia of institutions.

At the State and National level, the GECs comprise a comprehensive educational system, serving as the primary coordinating body for the preparation of faculty, health professions students, and health care personnel to better serve the Nation's elderly. GECs use ambulatory care centers, hospitals, long-term care facilities and senior centers to provide appropriate educational experiences to health professions students and providers, to prepare them to deliver humane and dignified care and to be responsive to older individuals whose ability to care for themselves has been reduced by physical and/or mental disorders.

In FY2002, a total of $11.6 million was awarded to 41 GECs. In FY2003, a total of $15.6 million was awarded to 46 GECs.

GERIATRIC ACADEMIC CAREER AWARDS (GACAs)

The Bureau of Health Professions made awards for the first time under the newly established Geriatric Academic Career Award (GACA) Program in September 1999. Intended to support the development of newly trained geriatric physicians into first rate teachers of geriatrics, GACAs provide five years of support for academic career development. The awards require and allow the recipients to devote the bulk of their academic careers to teaching geriatrics to a wide range of health care professionals. The career development plans of awardees show a strong commitment to the development of best practices in the care of older patients. They have chosen a wide range of topics to devote their time to developing, including direct service projects such as mobile geriatric assessment clinics for older people living in rural areas, home-based geriatric assessment, and geriatric rehabilitation, all aimed at restructuring and facilitating delivery of care to the elderly; interdisciplinary care for the chronically ill and the development of chronic disease state "glide paths;" effective clinical teaching of palliative care for the elderly; geropharmacy and nutrition; acute care of the elderly; culturally competent care of the elderly; infection control interventions in long-term care; development of resource materials on organ system normative aging; hospice care; special issues in the delivery of rural health care by family practitioners; and the design and implementation of community-based programs which allow the frail elderly to remain in their homes.

The program contributes not only to the training of physicians but to many other health professionals who have responsibility for the care of the elderly. As specified in the statutory language, awards were made directly to individuals who were required to obtain the commitment of their employing institution for a period of five years. In FY2002, $1.8 million was awarded to 33 medical school junior faculty members. In FY2003, 4.0 million was awarded to 33 continuing and 37 new junior faculty members. Each faculty member received $57,007 in FY2003.

QUENTIN N. BURDICK PROGRAM FOR RURAL INTERDISCIPLINARY TRAINING

The *Quentin R. Burdick Program for Rural Health Interdisciplinary* promotes rural health care practice by providing support for the interdisciplinary training of health professions students. The program requires two or more applicant organizations to apply together in order to foster collaborative efforts to promote and retain health professionals in rural areas. Specific programs demonstrate innovation in interdisciplinary training and curriculum development, and forge linkages among academic health training institutions and rural health care agencies and practice facilities, State health departments, and health professionals who practice in rural areas. Though not limited to training in geriatrics, some projects focus prominently on geriatric care. In FY2002, five projects for a total of $1.2 million focused primarily on geriatric care, and in FY2003, three projects for a total of $665,000 focused on geriatrics.

ALLIED HEALTH PROJECT GRANTS

Since 1990, 159 Allied Health Special Projects grants have enabled schools to

- increase enrollment in allied health disciplines experiencing shortages and in disciplines whose services are in high demand by elderly people;
  provide rapid transition training to students with baccalaureate health science degrees;
- establish community-based training programs linking academic health centers with rural clinical settings;
- provide advanced training for practicing allied health professionals;
  establish or expand clinical training in medically underserved and rural communities;
- develop curricula that emphasize disease prevention, health promotion, geriatrics, ethics, and long-term, home health and hospice care;
- promote interdisciplinary training in geriatric assessment and rehabilitation;
- establish or expand demonstration centers that focus on innovative linkages between allied health clinical practice, education and research; and
- establish or expand graduate programs in behavioral and mental health professions.

CHIROPRACTIC DEMONSTRATION PROJECTS PROGRAM

Chiropractic Demonstration Project grants support research in which chiropractors and physicians collaborate to identify and provide effective treatments for spinal and/or lower back conditions. Chiropractic Demonstration Projects must, in addition to addressing effective treatment of spinal and/or lower back conditions and emphasizing collaboration between chiropractors and physicians:

- Include a strong research protocol that will result in a significant expansion of documented research that is suitable for publication in refereed research-oriented and other health professions journals;

- Include explicit strategies for case-finding and direct comparison of chiropractic with other forms of treatment. Results must be generalizable to clinical practice settings where patients with spinal and/or lower-back conditions are treated; and

- Include racial and ethnic minorities and women in study populations whenever feasible.

In FY 2003, a funding priority was given to qualified applicants who devoted significant project resources to research in geriatrics. Three grants were funded and met the geriatrics priority.

AREA HEALTH EDUCATION CENTERS PROGRAM

The Area Health Education Centers (AHEC) are an active provider of continuing education (CE) for primary health care providers. Encompassing approximately 43 states, these Federally funded AHEC programs feature a wide array of programs and topics. AHEC CE programs focus on geriatrics as one of the most frequently requested and offered topics. Programs provide this education as part of broader goals and objectives specific to the AHEC legislative intent. In October 2003, a summary of the AHEC CE offerings in geriatrics in 40 AHEC programs, were as follows: a total of 464 programs was offered, 148 were offered via distance learning methodologies. A total of 14,803 CE participants attended these geriatric programs; of these, 1,658 were distance learning participants.

BIOTERRORISM TRAINING AND CURRICULAR DEVELOPMENT

The Bioterrorism Training and Curricular Development Program (BTCDP) funded 32 programs in FY03. This Cooperative Agreement program was developed to prepare a comprehensive health care workforce to possess the knowledge, skills and abilities to: (1) recognize indications of a terrorist event or other public health emergencies, (2) meet the acute care needs of patients, including pediatrics and other vulnerable populations in a safe and appropriate manner, (3) rapidly and effectively alert the system of such an event at the community, state, and national level and (4) participate in a coordinated, multidisciplinary response to terrorist events. These 4 components will equip a workforce of health care professionals to address the medical

consequences of bioterrorism and improve public health preparedness and team responsiveness. The BTCDP has two components: Continuing Education for health professionals and Curriculum development, revision, and adaption in health professions schools.

GERIATRIC EDUCATION FUTURES PROJECT

In 1994-1995, the Bureau of Health Professions sponsored a major assessment of the state of workforce development in geriatrics. The effort resulted in the production of *A National Agenda for Geriatric Education* with specific recommendations for action in eleven broad areas. In Fiscal Year 2003, the Bureau is beginning a follow-up to the *National Agenda.* Through various efforts, the Bureau will track where health professions training is in relation to the earlier recommendations and where workforce development activities need to go in light of progress-to-date and recent changes in health care delivery systems.

PUBLICATIONS

A National Agenda for Geriatric Education: Forum Report, Volume 2. Rockville, MD: Interdisciplinary, Geriatrics and Allied Health Branch, Division of Associated, Dental and Public Health Professions, Bureau of Health Professions, Health Resources and Services Administration, Public Health Service, U.S. Department of Health & Human Services. 1996

A National Agenda for Geriatric Education: White Papers, Volume 1. Rockville, MD: Interdisciplinary, Geriatrics and Allied Health Branch, Division of Associated, Dental and Public Health Professions, Bureau of Health Professions, Health Resources and Services Administration, Public Health Service, U.S. Department of Health & Human Services. 1995

Geriatric Education Centers: A Resource Directory, Rockville, MD: Interdisciplinary, Geriatrics and Allied Health Branch, Division of Associated, Dental and Public Health Professions, Bureau of Health Professions, Health Resources and Services Administration, Public Health Service, U.S. Department of Health & Human Services. 1998

BUREAU OF PRIMARY HEALTH CARE

Introduction

On October 26, 2002, the President signed the Health Care Safety Net Amendments of 2002. This Act amends the Public Health Service (PHS) Act to reauthorize and strengthen the health center program and to establish the Healthy Communities Access Program. The health center program is designed to promote the development and operation of community-based primary health care service systems in medically underserved areas for medically underserved populations. Legislation governing this program can be found in section 330 of the PHS Act, as amended (42 U.S.C. 254b). The Health Care Safety Net Amendments, under section 330(a)(1) of the PHS Act, defined the term "health center" as an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing.

The health center program is administered by the Health Resources and Services Adminstration's Bureau of Primary Health Care. The mission of the Bureau of Primary Health Care (BPHC) is to increase access to primary and preventive care and to improve the health status of underserved and vulnerable populations. Over a five-year period (fiscal years 2002-2006), the President is committed to strengthening and expanding the health care safety net for those most in need. The President's Health Center Initiative expects to achieve its objective by creating 1,200 new/expanded health center access points, and serving an additional 6.2 million people through maintaining a commitment to community-based programs. In addition, the BPHC will ensure that health centers provide affordable, comprehensive, community-based, culturally and linguistically appropriate quality health care to their patients.

In fiscal year 2001, the health center program served 10.3 million patients with a budget of $1.179 billion (including the Federal Tort Claims Act Program). In fiscal year 2002, the first year of the President's Health Center Initiative, over 11.3 million patients received services with a budget of more than $1.343 billion. In 2003, the second year of the President's Health Center Initiative, the total number of comprehensive primary health care sites is estimated to reach nearly 3,600 serving 12.55 million patients with a budget of $1.505 billion.

According to the 2000 U.S. Census Bureau, the number of individuals 65 and older increased by 10 percent, from 31 million in 1990 to 35 million in 2000. In 2000, HRSA launched an initiative to increase access to comprehensive primary health care for elderly underserved patients. The four key areas are:

(1) Reimbursement (dual Medicare and Medicaid health coverage)
(2) Outreach (improved methods to bring older persons into care)
(3) Quality (appropriate health care specific to client needs)
(4) Identification of Best Practices

Since the beginning of HRSA's initiative, the percentage of seniors served has been consistent. Table 1 shows that a steady 7 percent of all health center patients served are seniors, even as the population of total persons served by health centers increased.

Table 1: Seniors* Served by Health Centers
Uniform Data System, 2000-2002

	Reporting Year		
	2000	2001**	2002**
Total persons served	9,600,158	10,280,747	11,318, 727
Total Seniors served	682,977	734,415	795,263

*"Seniors" defined as age 65 years and over.

**Numbers reflective of reporting health centers.

Reimbursement Activities:
HRSA is offering workshops to assist health centers in expanding their services as providers for Medicare. The workshop, "Medicare Risk Contracting," covers Medicare benefits, contracting, reimbursement, financial, facility, and operational issues for health centers and the populations they serve as well as information on the utilization and risk management for the Medicare population.

BPHC provided technical assistance to Primary Care Associations (PCAs) and health centers on the section 1115 Research and Demonstration waiver initiative and Pharmacy Plus. State and Regional Primary Care Associations enable BPHC in its mission because they represent safety net providers throughout the State, as well as collaborating with providers, policy makers, program administrators, and communities to advance the goals of BPHC.

Under the 1115 waiver program, the Centers for Medicare and Medicaid Services (CMS) allows states to develop a pharmaceutical benefit under the Pharmacy Plus Program for low-income seniors, individuals with disabilities, and other targeted populations as part of their Medicaid program. PCAs and health centers have the opportunity to play an important role in the success of the Pharmacy Plus program because Pharmacy Plus waivers require linkages to primary care. With these tools, health centers can take an active role in enrolling Pharmacy Plus beneficiaries in available insurance programs to improve reimbursement.

Outreach Activities:
HRSA encourages outreach efforts to elderly individuals who are vulnerable and in need of primary health care. Health centers provide a wide range of enabling services that are integral to sustaining improved health outcomes. Health center services closely related to the outreach goals include: case management, eligibility assistance, food bank/delivered meals, housing assistance, health education, transportation, home visitation, and special education programs. Thirty-three percent of health centers provide nursing home and assisted-living placement services.

The health center program has experienced a significant increase in the number of health center sites providing care to underserved populations between 2000 and 2002. Thirty-two percent of all health centers serve populations of one thousand or more elderly patients (see Table 2).

Table 2: Health Centers* Serving Greater than 1,000 Seniors
Uniform Data System, 2000-2002

	Reporting Year		
	2000	2001**	2002**
Total health centers	730	748	843
Total health centers serving 1,000 or more elderly patients	229	239	267

*Health centers may have multiple sites or access points per organization.
**Numbers reflective of reporting health centers.

Using the existing health center infrastructure, BPHC has expanded existing outreach activities to include the following partnership activities:

- Agency for Healthcare Research and Quality (AHRQ) developed the Staying Healthy at Age 50+, adapted from Put Prevention into Practice" educational materials. More than ten thousand publications were distributed to health centers.
- Geriatric Education Centers and Area Agencies on Aging conduct health promotion and disease prevention activities for the vulnerable and underserved elderly population. Examples of project activities included free health screenings and immunizations, as well as the dissemination of information on mental health, medication management, and nutrition to elderly individuals. Educational sessions for geriatric health professionals are also provided.
- The National Institute on Aging facilitates distribution of educational materials to health centers.

Quality Activities:
HRSA has addressed health outcomes among low-income elderly persons in primary care, preventive treatment, and alternative treatment using several clinical performance measures. These measures include socioeconomic status, insurance coverage, usual source of care, activity limitation, disease screening and treatment, and access to care. Efforts to enhance health care quality include:

- Geriatric Training modules for health center staff containing curricula and resource materials, key aspects of cultural delivery, and a resource directory targeted to health care

providers and executives.

- Education and training to increase awareness about elder homelessness in local communities was provided to health center providers. The training educates providers on the special healthcare and service needs of elderly homeless people and the barriers that they encounter when attempting to access services. It also presents service-delivery models from communities that are addressing multiple health care and social needs. These trainings are intended to improve the delivery of care to the approximately 15,000 people over the age of 65 who are served by Health Care of the Homeless programs each year.
- National Geriatric Directory of federal, state/territorial, and local resources. Topic areas addressed in the directory include general aging, care and resources, gender, ethnicity, identity, diseases and conditions, legal issues, and rural health.
- Materials developed with the Administration on Aging for the Caregiver Resource Room and the National Family Caregiver Support Program. These resources provide information to families, caregivers, and professionals about finding support, assistance, and services to caregivers. The Caregiver Support Program is closely linked to other parts of the nation's emerging home and community-based long-term care system and serves participants who have different needs for long-term care services.

Patient-related revenue from Medicare reimbursement to health centers average 6 percent (see Table 3). To assist HRSA-supported centers interested in expanding and/improving their services to the elderly, BPHC sponsored several training workshops. "Geriatrics and Community-Based Health Centers" is a one-day workshop designed to give health center providers and managers a comprehensive background in the principles and techniques of serving a geriatric population. The curriculum addresses why serving the elderly is important for a health center, evaluating a center's readiness to serve the elderly, establishing a geriatric program, and operational and clinical issues.

Table 3: Patient Related Revenue Among Community Health Centers
Uniform Data System, 2000-2002

	Reporting Year		
	2000	2001*	2002*
Patient Revenue (in dollars)	3,933,154,7272	4,423,253,477	5,212,249,417
Medicare Revenues(in dollars)	222,822,035	259,935,805	299,328,106

*Numbers reflective of reporting health centers.

Best Practice Activities:
HSRA-supported linkages with health centers and community resources develop greater resource capacity for effective interventions in elderly populations, providing models to facilitate programs and objectives. BPHC developed several products to facilitate adaptation of these programs into communities served by health centers.

- Developed a manual focusing on best practices serving elderly clients titled Optimum Geriatric Services. The manual was designed for use by health care providers and staff and based on a commissioned report on studies focusing on health practices among older populations served by health centers.
- Developed monographs based on findings from three health centers for health center administrative staff related to elderly clients titled Clinical and Facilities Considerations, and Reimbursement Models. These monographs include issues related to the Healthy Communities Access Program, the Program of All-Inclusive Care for the Elderly, and "Successful Clinical Models.

OFFICE OF RURAL HEALTH POLICY

The Office of Rural Health Policy (ORHP) was established in 1987 at the urging of the Senate Special Committee on Aging in order to address severe shortages of health services in rural areas, where one quarter of the Nation's elderly live. Aging-related issues are of particular importance to the Office, since rural counties have, on average, a higher percentage of individuals over 65 years of age than urban counties; and these residents are often poorer, sicker, and more isolated than their urban counterparts.

To strengthen support for health services in rural areas, the Office plays a collaborative role throughout the Department and with the States and the private sector. Within the Department, the Office advises the Secretary on the affects that Medicare and Medicaid programs have on rural health care, on the shortage of health care providers, the viability of rural hospitals, and the availability of primary care and also emergency medical services to elderly and other rural residents. The Office meets on a bi-monthly basis with key staff at the Centers for Medicare and Medicaid Services on key regulatory issues affecting the providers who serve rural communities. The Office also works with many of the associations and interest groups that focus on rural health issues, including the National Rural Health Association, the American Hospital Association, and the National Association of Community Health Centers.

The Office supports local and States initiatives to build rural health care services through almost $58 million in direct grants to rural communities. The Office also provides $8.5 million grants to states to support State Offices of Rural Health. These offices work with communities to support rural health activities, including recruitment and retention of rural providers.

HRSA CENTER FOR HEALTH SERVICES FINANCING AND MANAGED CARE

Third Party Reimbursement Training and Technical Assistance Program, HRSA has embarked on a 3-year program to improve the third party reimbursement (TPR)status of organizations funded directly by HRSA (i.e. HRSA grantees) and organizations funded by States and localities using HRSA grant funds along with State and local funds (i.e. HRSA subgrantees). Training and technical assistance is offered in each State in the areas of billing, coding, and collections, which is designed to help HRSA grantees and subgrantees improve revenues from third party sources.

Given the role HRSA-funded providers play in caring for the elderly, for example, 7.0% of the 11.3 million patients seen in Federally Qualified Health Centers are 65 years of age and older, the goal of the Third Party Training Program is to assure the HRSA funded providers know how to receive reimbursement from all available sources of revenue, including Medicare.

The ORHP also promotes informed policy making by administering a $5 million program of grants to support policy-relevant studies at established rural research centers throughout the country. These centers provide data capability on a wide range of rural health concerns, including areas relevant to the elderly such as Medicare financing and chronic disease management. One research center tracks rural participation in the Medicare + Choice program. Another looks at labor issues related to skilled nursing facilities.

The Office also administers a $25 million grant program to States to help them implement the Medicare Rural Hospital Flexibility Program. Under this program, rural hospitals that convert to a smaller Rural Critical Access Hospital can receive cost-based payments from the Medicare. The grants help States and rural communities plan and implement the conversion of rural hospitals, promote the development of new local networks of care, increase quality and reduce medical errors and help to integrate rural emergency medical services into the larger health care delivery system. The Small Hospital Improvement Program, another grant program within the Office, focuses on rural hospitals and provides $15 million to support quality improvement, compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 as well as activities to help hospitals adapt to Medicare's administered pricing systems.

In collaboration with other Federal agencies such as the Centers for Medicare and Medicaid, the Department of Agriculture, the Centers for Disease Control and the Agency for Health Research and Quality, ORHP sponsors workshops and seeks public advice on a range of rural health needs. These issues may included such issues as emergency medical services, managed care options for Medicaid and Medicare clients, physician recruitment, and rural economic development.

In 2001, the Office was asked to serve as the primary staff to the Secretary's Rural Initiative. This ongoing initiative looks at how the Department serves rural communities. In July of 2002, the Secretary released a report as part of that initiative entitled, "One Department, Serving Rural America, the HHS Rural Task Force Report to the Secretary. As a result of that initiative, Secretary Thompson created a new information resource for rural communities served by HHS

called the Rural Assistance Center or RAC. The RAC, which is supported and managed by ORHP, provides the public as well as health care professionals, researchers and community officials with an efficient source of information and referral on rural health and human service issues. The RAC, which is located in Grand Forks, North Dakota, employs information specialists who are available to provide customized assistance, such as web and database searches on rural topics and funding resources, linking users to organizations.

The Office also channels public advice on rural issues to the Department by staffing the Secretary's National Advisory Committee on Rural Health and Human Services, a citizen's advisory panel chartered in 1987 to address health care and human service issues in rural America. Prior to 2002, this Committee focused solely on health issues. However, as a result of the Secretary's Rural Initiative, the Committee was expanded to also focus on human service issues, including those related to serving the elderly.

HRSA is also funding a technical assistance project to help rural communities determine if frail elderly residents in their communities might benefit from receiving care through a Program of All-Inclusive Care for the Elderly (PACE). The purpose of the PACE model is to expand community-based long-term care options for dual-eligible (Medicare and Medicaid) seniors through comprehensive coordination of preventive, primary, acute, and long-term care services. It is a unique capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity that features a comprehensive medical and social service delivery system. There is little or no penetration of this model into rural areas. What is not known is how many rural providers are interested in the PACE model and how viable this model might be for meeting the needs of frail elderly in rural communities. The purpose of this initiative is to develop and implement a Rural PACE Technical Assistance Program to plan for and provide technical assistance to interested rural providers and to assess the relative level of expertise of these rural providers as it relates to the PACE program requirements. The goal is to provide a mechanism to provide technical guidance to rural providers about the PACE program in general, the processes for meeting the requirements of the PACE program and assistance in understanding how an organization or provider develops and applies for PACE provider status. The contract will also help HRSA to understand the level of interest to PACE by the rural providers and the relative capacity of these providers to become potential PACE providers. The program is a joint initiative of the Office of Rural Health Policy along with the Bureau of Health Professions' Office of Geriatrics, Quentin Burdick Program, Division of Medicine and Dentistry and the Division of Nursing.

HIV/AIDS BUREAU

Eleven percent of all newly diagnosed cases of AIDS is in persons 50 years and older. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funds the provision of HIV/AIDS services and is implemented by the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration. CARE Act programs provide services to underinsured and uninsured persons infected with and affected by HIV/AIDS. It is estimated that 5 - 8 percent of the persons served in CARE Act programs are 50 years of age and older. HAB is aware of the need for increased and more targeted research, outreach, and services directed to this 50 + population and have been active in various related activities.

HAB's Division of Training and Technical Assistance is conducting a research study that examines variations in service use and intensity by age to better understand the potential increased demand for medical care and other services as the HIV-infected population ages. Several HAB staff persons have been and continue to be involved in conducting data searches, participating in workgroups, and maintaining linkages with other Federal agencies and private organizations around the issue of older persons and HIV/AIDS. Bureau representatives make presentations at various national conferences to a wide variety of audiences about the epidemiological data for this population, special needs of this population, and prevention, outreach and treatment efforts being conducted and those still needed for this age group in order to make HIV/AIDS providers, clinicians, and consumers more aware of the trends and issues in this age group.

DEVELOPMENTS IN AGING
THE INDIAN HEALTH SERVICE

INTRODUCTION

The Indian Health Service (IHS) is responsible for providing health services to American Indian and Alaska Natives (AI/AN) who are members of federally recognized tribes. The IHS is the principal federal health care provider and health advocate for Indian people and its goal is to raise their health status to the highest possible level. In fiscal year (FY) 2002, the IHS provided health services to approximately 1.345 million American Indian and Alaska Natives who belong to more than 562 federally recognized tribes in 35 states. With approximately 12 percent of the IHS AI/AN user population 55 years and older, the IHS serves as the primary health care provider for approximately 161,000 older American Indians and Alaska Natives. This is a rapidly growing population, increasing by some 25 percent between the 1990 and 2000 census.

In addition to providing comprehensive health care to older American Indians and Alaska Natives, the IHS is engaged in efforts to improve tribal capacity in long term care and to reduce the impact of injury and preventable disease on AI/AN elders and their families.

At the community level, IHS, Tribal, and Urban Indian Health programs have developed innovative programs and services to enhance the care they provide to their elders. These efforts represent a focus on elder care in response to local priorities and need.

COMPREHENSIVE HEALTH CARE

Health services are provided directly and through tribally contracted and operated health programs. The Federal system consists of 36 hospitals, 59 health centers, 49 health stations, and 7 youth treatment centers. Through P.L. 93-638 self-determination contracts and compacts, American Indian Tribes and Alaska Native corporations administer 13 hospitals, 172 health centers, 84 health stations, 176 Alaska village clinics and 3 school health centers. 34 urban Indian health projects provide a variety of health and referral services to tribal members living in metropolitan areas.

In FY 2002 the IHS budget for clinical services was $1.891 billion, covering inpatient and outpatient services for all IHS users, including approximately 161,000 persons over the age of 54. Twenty eight percent of all IHS and tribal outpatient medical visits and inpatient discharges and 37 percent of all hospital days were provided to persons 55 years and older. An additional $99.7 million of the IHS FY 2002 budget was devoted to Preventive Health Services, including Public Health Nursing, Community Health Representatives (CHR), and immunization outreach. The IHS collected $485 million in Medicare and Medicaid reimbursement for services provided through IHS and tribally contracted and administered health programs. The IHS purchases care from over 9,000 private providers annually for care that cannot be provided within IHS or tribal facilities. In FY 2002, approximately $45 million of services were purchased from private providers to assist with care for beneficiaries 55 years and older.

DEVELOPMENTS IN AGING
THE INDIAN HEALTH SERVICE

The leading causes of death for persons 65 years and over are heart disease, cancer, diabetes, stroke, chronic lung disease, unintentional injury, pneumonia and influenza. Death rates from diabetes, pneumonia and influenza, and unintentional injuries exceed the U.S. all races rate, representing a substantial disparity in health status for older American Indians and Alaska Natives. Reducing this disparity is a clear and unequivocal goal of the Indian Health Service.

In providing health care for older American Indians and Alaska Natives, the IHS and Tribal health programs seek to provide comprehensive, community-based care with a focus on prevention of disease and disability. This care begins in a competent and culturally proficient primary care system based in the community and responsive to community priorities and needs. Public health nursing works with the primary care provider to coordinate care and provide outreach into the home. The CHR programs, paraprofessional staff from the community who know the elders of their community, provide a variety of services, from translation and transportation to personal care, health education, and elder wellness programs. Environmental services are part of the package of comprehensive health care provided by the IHS, ensuring safe water and sanitation. The Dental program provides dental services, including prostheses.

SPECIAL INITIATIVES

The IHS has developed a number of special initiatives and projects to improve the health status of AI/AN elders. These efforts focus on support of the IHS, Tribal, and urban health programs to provide high quality clinical care and reduce the impact of injury and preventable disease on AI/AN elders and their families. Efforts also focus on support of Tribes as they improve capacity in long term care for the elderly and disabled in their communities.

In FY 2003, the IHS, in collaboration with the Administration for Native Americans (ANA), awarded 20 grants under the **Elder Health Care Initiative Long Term Care Grants** program totaling nearly one million dollars a year for three years to Tribal and Indian organizations. These grants support efforts to plan and deliver long term care services at the Tribal and community level. Project proposals include the development of elder day programs, assisted living, and personal care services. The IHS has also funded the **National Indian Council on Aging (NICOA) Tribal Long Term Care Technical Assistance Center**, the **Home and Community Based Care Resource Guides for Tribal Organizations** and a pilot study of the long term care needs of urban American Indian and Alaska Natives.

In partnership with the Administration on Aging, the IHS convened the **April 2002 Roundtable in AI/AN Long Term Care**. The report that followed was widely

disseminated and has been influential in shaping the course of policy and planning for long term care in Indian country.

Through the **IHS Elder Care Initiative**, the agency has developed and disseminated tools for improved clinical care and program development, including preventive care guidelines for the elderly and tools for geriatric assessment. In partnership with the American Geriatric Society and a number of academic institutions, the Elder Care Initiative promotes opportunities for geriatric training and education. A current contract with the Alaskan Native Tribal Health Consortium focuses on a 3-year project to train teams from across the 12 IHS Areas in palliative and end-of-life care. The Elder Care Initiative has fostered a network of professionals with geriatric expertise and interest throughout Indian country.

The **Women's Health Initiative** of the IHS has focused attention on reducing preventable illness in older women, funding a mobile mammography unit to reach underserved areas in the northern plains and in Arizona. The **Public Health Nursing** program is developing mobile computing software to enhance the ability of public health nurses to provide home based assessment and care to frail elders. The national **Community Health Representatives (CHR)** program supports geriatric education for these community based paraprofessionals.

The **Native American Cardiology** program, a collaboration between the Phoenix, Tucson, and Navajo Areas of the IHS, the University of Arizona, the Southern Arizona Veterans Administration Healthcare System, regional hospitals and Tribal communities, brings high quality, culturally proficient cardiology care to the reservation communities where over half of all AI/AN elders live.

The **Injury Prevention** program provides funding to IHS Areas for injury reduction efforts, including a variety of Tribal programs aimed at reducing falls and injuries among the elderly. The Cancer Control program has initiatives focusing on smoking cessation and the prevention of smoking related disease and disability.

With **2003 research and evaluation** funds, the IHS supported Area priorities with a project that seeks to identify the elder care needs of Alaska Natives and a study of the health status of the emerging elders of Fort Peck, Montana.

The **National Diabetes Program** promotes collaborative strategies for the prevention of diabetes and its complications in the 12 IHS Areas through coordination of a network of 19 Model Diabetes Programs and 13 Area Diabetes Consultants. The Diabetes Program also manages the Special Diabetes Program, working directly with Tribes and Indian communities to prevent diabetes and its complications.

The **Director's Prevention Initiative** will focus agency efforts on the critical task of preventing disease and disability and supporting healthy communities. The IHS

Prevention Task Force, with broad representation from the IHS and Tribal programs, has been charged with identifying the key components for a coordinated and systematic approach to preventive health activities at all levels of health care for AI/AN.

LOCAL PRIORITIES AND INNOVATION

In response to local priorities, the IHS, urban, and Tribally contracted and administered health programs are providing innovative programs to meet the needs of their elders. Often this effort involves building a long term care infrastructure to assist families as they care for their elders. A few of these initiatives are described below.

The **Warm Springs, Oregon** IHS clinic has developed a home visit program for elders. The physician, with the assistance of the Community Health Representative, assesses elders in their home, with family, bridging the gap between the clinic and the elders.

In **Kayenta, Arizona**, the IHS program has developed a comprehensive elders program including an interdisciplinary clinic for evaluating frail elders and a case management system to address the complex medical and social needs of elders at risk. In **Fort Defiance, Arizona**, an interdisciplinary elder care task force brokers services from multiple agencies and organizations to support frail elders in the community.

The Navajo Nation Office on Aging has made available $100,000 to be spent over the next two years to provide eyeglasses to the Navajo elderly (age 60 and above). **Navajo Area IHS** eye clinics are providing the eye examinations, the frame selecting service, and dispensing the finished pair of eyeglasses.

Tohono O'odham elders in nursing homes near the reservation can count on a visit from an IHS physician who knows their community and serves as their advocate. As a result, in one commonly used private nursing home, Tohono O'odham traditional healers are now welcome and attention has been focused on making the food more palatable for Tribal elders.

The **Mississippi Choctaw Nation** owns and administers a nursing home which is Medicare and Medicaid certified and financially independent, serving not only Tribal members, but reaching out to surrounding non-Tribal communities.

The **Lummi Nation** in Washington recently converted an underused assisted living facility to elder housing while at the same time ensuring that elders in the housing continue to have access to personal care services through the State home and community based care program.

The **Pueblo of Zuni**, in New Mexico, has built a community-based long term care system by coordinating services with disparate funding sources, provided by various agencies

(IHS and Tribal) to provide the care their elders need in the home setting they most prefer.

The **Cherokee Nation of Oklahoma** is investigating the feasibility of becoming a Program of All-Inclusive Care for the Elderly (PACE) provider, bringing this program of integrated and coordinated medical and long term care to their elders and the elders of nearby Tribes.

The **Seattle Indian Health Board** is engaged in a study to identify the long term care needs of urban elders. With funding from the IHS Elder Health Care Initiative grants, they will develop services to respond to the needs they have identified.

A number of IHS and Tribal sites have developed **geriatric assessment clinics**, targeting frail elders with multiple medical and social problems. This effort involves translating models of interdisciplinary care developed in academic settings for use in rural, primary care based clinics and hospitals.

Hospice programs developed at Zuni, New Mexico, in Bristol Bay, Alaska, and in the Cherokee Nation of Oklahoma and elsewhere now bring culturally appropriate end-of-life care to rural Tribal elders.

CONCLUSION

The IHS provides high quality, comprehensive health care to older American Indians and Alaska Natives through the IHS, Tribally contracted and administered health programs and through support of urban Indian health centers. With special initiatives, the IHS supports Tribal and community based efforts to develop long term care resources in AI/AN communities and to reach those communities suffering from the greatest health disparities. With creativity and innovation, Tribal, urban, and the IHS health programs continue to develop enhanced programs to meet the needs of the elders they serve. Ultimately, the path to health for elders is through healthy communities.

In calendar years 2001 and 2002, SAMHSA engaged in two key activities on behalf of older Americans:

1. **PRISM-E (Primary Care Research in Substance Abuse and Mental Health Services for the Elderly)**: This study is designed to identify differences in clinical and cost outcomes between models referring older persons to specialty mental health/substance abuse services outside the primary care setting and those providing services within the primary care setting itself. The study is being carried out in three phases, covering a 6-year period. In Phase I, a statistical power analysis was calculated to determine the enrollment numbers needed to adequately test study hypotheses. In Phase II, nearly 2,300 persons have been randomized to either integrated or referral models of mental health/substance abuse care. Clinical screenings were conducted on over 27,000 persons. Participants were assessed at baseline, 3 and 6 months, to determine changes in clinical symptoms and functioning over the course of treatment. Patients have been enrolled from 11 sites, which represent roughly 50 clinical settings and include a variety of providers from managed care environments, community health clinics, VA facilities, and group practice settings. The study sites represent a rich diversity of ethnic/minority and rural/urban populations. Database development, data analysis, and presentation and paper-writing is the focus of Phase II of the study, which will last for 2 years, ending August 2004. For more information regarding PRISM-E, please see the attached two documents.

2. **Technical Assistance Center for the SAMHSA Targeted Capacity Expansion (TCE) Program for Older Adults, The Positive Aging Resource Center (PARC)**: The mission of PARC is to improve the mental health of older adults by providing assistance in the implementation and evaluation of innovative and evidence-based practices to increase the quality of mental health services and to expand access for all older adults including underserved, rural and ethnically diverse persons and their families. There are nine sites across the nation developing a systematic process for transferring knowledge about research, best practices, and policies to assist in the development and implementation of evidence-based, culturally competent, and financially sustainable service programs. For more information regarding PARC and the current nine sites follows.

Technical Assistance Center for the SAMHSA TCE Program for Older Adults: The Positive Aging Resource Center (PARC)
Overview of PARC Services

8-27-03

Background

The Positive Aging Resources Center (PARC) is part of the Targeted Capacity Expansion (TCE) initiative funded by the Substance Abuse and Mental Health Care Administration (SAMHSA) in 2002.

Mission/Aims

Our mission is to improve the mental health of older adults by providing assistance in the implementation and evaluation of innovative and evidence-based practices to increase the quality of mental health services and to expand access for all older adults including underserved, rural and ethnically diverse persons and their families.

We currently work with 9 TCE sites across the nation to develop a systematic process for transferring knowledge about research, best practices, and policies to assist in the development and implementation of *evidence-based, culturally competent, and financially sustainable* service programs.[1] The PARC is devoted to educating older adults and their families about signs and symptoms of mental health conditions, and providing them with tools to more effectively participate in their own care through the healthcare system.

Focus of Our Technical Assistance (Content Areas)

We serve a broad audience including:

- Health service agencies interested in developing and implementing mental health service programs for older adults
- Health providers intending to provide geriatric mental health services
- Older adults and their families from diverse ethnic and cultural backgrounds
- Policy makers interested in learning about mental health service issues related to aging populations.

To encourage improvements in mental health service delivery that will lead to measurable improvements in consumer outcomes, we are a resource to mental health programs, providers, and consumer groups, particularly in the following areas:

1. Evidence-Based Practice (EBP)
2. Sustainable Infrastructure Development
3. Implementation Process Evaluation
4. Treatment Guidelines
5. Instruments for Screening
6. Outcome Evaluation
7. Cultural Competency
8. Outreach Strategies
9. Integration of Care
10. Patient Self-management
11. Older Adult education
12. Family and caregiver education

[1] The 9 PARC partners are: COTTAGE Expanded Elder Services Program, Tucson, AZ; ElderLynk Expansion Program, Kirksville, MO; Project Focus, City of El Paso, El Paso, TX; Senior Behavioral Health Service Program, University of California, San Francisco, San Francisco, CA; Health Improvement Program for the Elderly, Jewish Family and Children's Service of Southern Arizona, Inc., Tucson, AZ; Kajsiab House, Madison, WI; La Clinica del Pueblo, Washington DC; Tiempo de Oro, Valle del Sol, Phoenix, AZ; Senior Outreach Program, Unity Health System, Rochester, NY.

Methods of Technical Assistance

Consultation: With its rich faculty through a consortium of nationally known experts in mental health, aging, health services, system integration, outcome evaluation, policy, and older adult participation, the PARC arranges individual and/or group educational sessions to facilitate problem-based learning and the development of innovative strategies

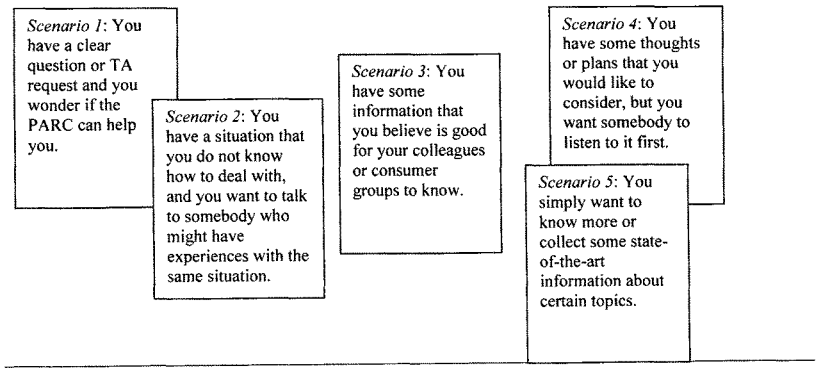
Coaching: PARC identifies a "coach" for each of its partner sites under the TCE program. Coaches function as a facilitator to assist the service site in designing, planning, and implementing program plans. Coaches also act as a liaison between PARC and the site(s), to keep PARC staff informed of site-specific needs and to provide proactive technical assistance around program development and implementation.

Joint-Learning through Teleconferencing: PARC performs a convening function by providing opportunities for participating program administrators, clinicians, researchers, and older adults to share their experiences and expertise with each other on various topics. The choice of these topics is based on both the pronounced needs through the received TA requests and the needs perceived by the PARC.

Training: PARC may provide training and continuing education on some common thematic topics related to the aim of providing high-quality care for older adults with mental health problems. The training activity is currently arranged on the needed basis. Telecommunication technology may be used in the future.

Dissemination through the World Wide Web: PARC also functions as a clearinghouse to provide information relevant to mental health care for the aging population through the Web to providers, older adults, caregivers, and family members.

When and How to Contact Us



A number of points of contact can be made:

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PROGRAM TITLE: PRISM-E (Primary Care Research in Substance Abuse and Mental Health Services for the Elderly)

BACKGROUND/NEED: Many older individuals experience serious mental health and/or substance abuse (MH/SA) problems that affect their quality of life as well as their ability to function independently in the community. Although prevalence rates vary in epidemiological studies among the elderly, it is clear that elderly individuals experience high rates of depression and anxiety disorders, as well as alcohol abuse and dependence. Older adults seek and receive MH/SA services more often from their primary care providers than from specialty MH/SA providers. With the projected increase in the number of older Americans in the years to come, it is evident that both the clinical and policy communities need to be well informed as to the nature and effectiveness of different service delivery models for treating mental health and substance abuse (MH/SA) problems.

The Substance Abuse Mental Health and Services Administration (SAMHSA) has developed a multisite study to compare the effectiveness of service delivery models that treat older adults with Mental Health and Substance Abuse (MH/SA) problems in primary care as opposed to specialty MH/SA settings. The study hopes to identify differences in clinical and cost outcomes between models referring consumers to specialty mental health and/or substance abuse services outside the primary care setting and those providing such services within the primary care setting itself.

GOALS/OBJECTIVES: The study is designed to identify differences in clinical and cost outcomes between models referring older persons to specialty mental health/substance abuse services outside the primary care setting and those providing such services within the primary care setting itself.

Anticipated contributions to the fields of aging, mental health, and substance abuse include: the statistical power afforded by a large sample of participants to test a number of important hypotheses; it is the largest study of depression in the elderly; it is the largest study of alcohol use in the elderly; this is the first study of integration versus referral service models in the elderly; past studies look at usual versus collaborative care; this is the first effectiveness study of integration in the elderly; other major studies focus on compliance to clinical guidelines; the PRISM-E study focuses on real world integration and diverse clinical sites.

EVALUATION/PERFORMANCE MEASURES:
This study has been carried out in three phases, covering a 6-year period. The project is currently in its 5th year as of may, 2003. The intent of this study was to randomize a large number of older persons with MH/SA problems to either integrated or referral models of MH/SA care. A statistical power analysis was calculated in Phase I of the study to determine the enrollment numbers needed to adequately test study hypotheses. In Phase II of the study, participants were assessed at baseline, 3 months, and 6 months to determine changes in clinical symptoms and functioning over the course of treatment. Patients have been enrolled from 11 sites, which represent roughly 50 clinical settings and include a variety of providers from managed care environments, community health clinics, VA facilities, and group practice settings. The study sites represent a rich diversity of ethnic/minority and rural/urban populations.

A data repository of the multi-site study is being maintained at the Harvard Coordinating Center. Database development, data analysis, and presentation and paper-writing is the focus of Phase II of the study which will last for two years, ending on August, 2004. The outcome and process databases have been finalized and consist of two core elements: A consumer-level database and a project-level database. The consumer-level database will consist of a merged data set that includes information about individual socio-demographic characteristics, baseline and follow-up assessment data on target condition and severity, satisfaction, stigma, cultural issues, and functional outcomes. The project-level database will consist of qualitative characteristics of programs, participants, and contexts, including data on populations, treatment or service models and components, implementation problems, local environmental contexts, and evaluation methods. An analytic database is being derived from the qualitative process evaluation that can be used for statistical analyses. A third database is still under construction, and encompasses cost and claims data that will consist of all claims data identified as useful for addressing cost study questions. This database will also integrate client-level data obtained directly through CMS from Medicaid and Medicare databases. Access to these data were negotiated through an interagency agreement between SAMHSA and CMS.

The following domains will be measured in the study:

1) A large battery of treatment outcome measures for all participants
2) Quantitative measurement and qualitative description of service interventions through process evaluation, detailed program manuals, and structured site visits
3) Measures of degree of integration of clinical sites on seven dimensions
4) Survey of provider attitudes
5) Measures of operational costs, including pharmacy data

BUDGET/EXTENT OF INVESTMENT: Study sites underwent two rounds of peer-reviewed competition to be in the multisite study. SAMHSA's investment in this project over the initial 4-year study period has been $14,319,266. An additional 2-year supplement to the Coordinating Center was awarded, adding and additional $1,000,000 in SAMSHA funds. Further investments have been made by other federal agencies: a) HRSA has contributed $676,000 over the 4 year project period to provide additional services enhancements; b) The Department of Veterans Affairs (VA) has made a substantial contribution to the study by providing data from 5 clinical sites. They have provided 3.5million to five VA medical centers in direct funding for two years of the study. The VA system has also contributed in kind support to help with the management of the study through a distinct VA coordinating body. An interagency agreement with the VA committed the clinical operations of the five VA study sites to conform to the study protocol. These sites were chosen through two phases of competition; c) An interagency agreement with the Centers for Medicare and Medicaid services (CMS) will contribute relevant Medicaid and Medicare data to link to outcome data from the study participants. HRSA continues to provide service enhancement funds during the 2-year study extension to the three sites that are federally qualified health clinics, for an additional investment of $312,000.

OUTPUTS/ACCOMPLISHMENTS/BARRIERS: This initiative includes the active collaboration of all three SAMHSA centers, with CMHS as the lead, the Health Resource Services Administration's Bureau of Primary Care (HRSA), The Department of Veterans Affairs, (VA), and The Centers for Medicaid and Medicare Services (CMS). Harvard Medical School, Brigham & Women's Hospital, and John Snow, Inc. have joined together to serve as the Coordinating Center (CC) for this multisite study. The Coordinating Center's role is multifaceted, providing leadership, administrative support, and technical expertise in the development and implementation of the multi-site protocol.

The CC has assembled a multidisciplinary and multicultural team of investigators and consultants with expertise in the major technical areas relevant to the program. These areas include geriatrics/gerontology, mental health, substance abuse, primary care, cost and health economics, and multi-site research methods. The CC staff has extensive experience in managing large studies and in providing training and technical assistance to community-based health care organizations.

The study has conducted 40,000 clinical screenings on over 25,000 persons. The study exceeded the enrollment targets set by the study, with 2271 participants enrolled. The rate of participant follow-up has been high, reaching nearly 80% at most sites for three and six month follow-ups.

Through the work of primary investigators at study sites, multiple presentations and symposia have been given in a variety of national conferences over the last several years to introduce the study and the design. Multiple presentations have been given at conferences sponsored by The Gerontological Society of America (GSA), American Psychiatric Association (APA), and the UPBEAT National Meeting sponsored by the VA.

Several publications of findings from site-specific data or the screening data have been accepted for publication. The Steering Committee has designated a set of about two dozen core papers that have been outlined and are currently being developed for publication. Additional papers are also being organized or are underway that address secondary questions from the multisite dataset or from a variety of unique data collected at the site-level only. For example, several VA sites have collected additional data to address questions about care for those persons having post-traumatic stress disorders.

Funders/Sponsors

Substance Abuse and Mental Health Services Administration (SAMHSA)
* CMHS (Center for Mental Health Services) (Lead)
* CSAT (Center for Substance Abuse Treatment)
* CSAP (Center for Substance Abuse Prevention)

Department of Veterans Affairs (VA)

Health Resources Services Administration (HRSA)

Center of Medicaid and Medicare Services (CMS)

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Project Description

Many older individuals experience serious mental health and substance abuse (MH/SA) problems that affect their quality of life as well as their ability to function independently in the community. Although prevalence rates vary in epidemiological studies among the elderly, it is clear that elderly individuals experience high rates of depression and anxiety disorders, as well as alcohol use disorders. With the projected increase in the number of older Americans in the years to come, it is evident that both the clinical and policy communities need to be well informed as to the nature and effectiveness of different service delivery models for treating MH/SA problems.

Since older adults seek and receive MH/SA services more often from their primary care providers than from specialty MH/SA providers, the Substance Abuse Mental Health and Services Administration (SAMHSA) has developed a multisite study to compare the effectiveness of service delivery models that treat MH/SA problems in primary care as opposed to specialty MH/SA settings. The study aims to identify differences in clinical and cost outcomes between models referring consumers to specialty mental health/substance abuse services outside the primary care setting and those providing such services within the primary care setting itself.

This 6-year study has been conducted in three phases; the study is currently in its fifth year. Nearly 2300 persons have been randomized to either integrated or referral models of MH/SA care. Clinical screenings were conducted on over 27,000 persons. Participants were assessed at baseline, 3 months, and 6 months to determine changes in clinical symptoms and functioning over the course of treatment. Persons were enrolled from 10 experimental sites, and from one additional quasi-experimental site, which represent roughly 50 clinical settings and include a variety of providers from managed care environments, community health clinics, Department of Veterans Affairs (VA) facilities, and group practice settings. Harvard Medical School, Brigham & Women's Hospital, and John Snow, Inc. teamed up to serve as the Coordinating Center (CC) for this multisite study. The CC's role is multifaceted, providing leadership, administrative support, centralized quality control, technical expertise in the development and implementation of the multisite protocol and design, and analytic expertise and support. The CC has taken the lead in designing and implementing the cost study portion of the project, and is also responsible for collecting and analyzing clinical outcome and cost data, as well as descriptive data on the integrated and referral models of care.

The CC has assembled a multidisciplinary and multicultural team of investigators and consultants with expertise in the major technical areas relevant to the program. These areas include geriatrics/gerontology, mental health, substance abuse, primary care, cost and health economics, and multisite research methods. The CC staff has extensive experience in managing large studies and in providing training and technical assistance to community-based health care organizations. Through these experiences, CC staff has developed the capabilities to work successfully in the collaborative processes.

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Enrollment
Depression alone—1,101 persons
At-risk drinking alone—476
Anxiety disorder alone—75
Dual diagnosis—592
Total—2244 persons

Grant Data
Catalogue Number of Federal Assistance: 93-230
Phase I: 10-1-98 to 08-31-99
Phase II: 9/1/99 to 8/31/02
Phase III: 9-1-02 to 08-31-04

This initiative was funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA has three centers: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT), and the Center for Substance Abuse Prevention (CSAP). All three centers were involved in this project, with CMHS serving as the lead. The Department of Veterans Affairs (VA), the Health Resources Services Administration (HRSA), and the Centers for Medicare and Medicaid Services (CMS) provided additional support and collaboration.

To date, total funding from SAMHSA has been $15.3 million to fund 6 study sites (including one VA site) and a study Coordinating Center. HRSA has contributed $676,000 to enhance services in community health centers so that they could better conform to the study model criteria. VA has contributed $3.5 million for the direct clinical support of 5 VA study sites. Additional support was received from Center for Medicare and Medicaid Services (CMS) in the form of access to Medicare claims data for the cost studies.

Anticipated Contributions to the Fields of Aging, Mental Health, and Substance Abuse:

- Power to Test a Number of Primary and Secondary Hypotheses
- Largest study of depression in the elderly
- Largest study of alcohol use in the elderly
- First Study of Integration vs. Referral Service Models in the Elderly
- Looks at integrated care vs. enhanced referral care rather than usual vs. collaborative care
- First Effectiveness Study of Integration in the Elderly
  - Other major studies focus on compliance to clinical guidelines
  - PRISM-E focuses on "real world" integration and diverse clinical sites
- Large sample of ethnic minority elderly (42% of total sample)

Accomplishments to Date:

- Standardization of Service Delivery Models by Establishment of a Set of Minimum Criteria
- Application of Uniform Brief Alcohol Intervention
- Development and Implementation of Common Research Protocol and Assessment Battery, including Standard Procedures for Randomization, and Data Collection
- Development and Implementation of Provider Survey
- Development and Implementation of cross-site Process Evaluation
- Site Visits at all Study Sites
- Development/Application of Culturally Sensitive Research Instruments
- Development of Comprehensive Cost Study
- Interagency Agreement with CMS (formerly HCFA)
- First Study of Integration vs. Referral Service Models in the Elderly
  - Past studies look at usual vs. collaborative care
- First Effectiveness Study of Integration in the Elderly
  - Other major studies focus on compliance to clinical guidelines
  - PRISM-E focuses on "real world" integration and diverse clinical sites
- Development and implementation of Consumer Advisory Councils at local and national levels; Active participation of consumers in many aspects of study
- Development of service model manuals at each service-study site

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Philadelphia VA Medical Center
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Presentations:

- UPBEAT National Meeting Presentation – Ed Olsen, Maria Llorente
- GSA 2000 – Designing A Multi-Site Effectiveness Study In The Real World – PRISM-E Study Investigators
- GSA 2000 – Conceptualizing And Measuring Dimensions Of Integration – PRISM-E Study Investigators
- GSA 2000 – Integrated Vs Referral Models Of Geriatric MH/SA Services: Process Evaluation – PRISM-E Study Investigators
- GSA 2000 – Implementing Cultural Competence In Minority MH/SA Research – PRISM-E Study Investigators
- GSA 2000 – Preliminary Results Examining Multi-Site Variation In Case Identification – PRISM-E Study Investigators
- AAGP 2001 – The Impact of Beliefs About Depression Among Elderly Primary Care Patients – D. Oslin, C. Zubritsky, I. Katz, J. Morrison, J. Coyne
- The PRIMSMe Study: Iowa SAMHSA Summit – Sue Levkoff
- IPA 2002 – Primary Care Research in Substance Abuse and Mental Health in the Elderly (PRISM-E) – Maria Llorente, Sue Levkoff, Ed Olsin
- APA 2001 – State of the Art and Science in Substance Abuse Prevention and Treatment – Paul Brounstein, Myron Belfer
- APA 2002 – Barriers To Medical Care And Family Involvement In Medical Treatment – Steven L. Sayers, Tracela M. White, Cortnie Stanton, Patricia Walker, David Oslin, Cynthia Zubritsky, Joel Streim and Ira Katz
- AAGP 2002 – The PRISM-E Study: A Multi-site Comparison of Integrated versus Referral Mental Health and Substance Abuse Services in Primary Care – Steven Bartels and the PRISM-E Investigators
- APA 2002 – From Research to Practice: Primary Care Research in Substance Abuse and Mental Health Services for the Elderly (PRISM-E) – Sue Levkoff and Maria Llorente (Chairs), Jack McIntyre, Hongtu Chen, Cynthia Zubritsky, David Oslin, Steven Bartels
- NAMI 2002 – Consumers in Mental Health Research – Steven Bartels, Jack McIntyre, Rosa Wims, and Trudy Persky
- AAGP 2002 – Functional and symptomatic outcomes between two models of care for at-risk drinking in older primary care patients – Fredric Blow, David Oslin
- AAGP 2002 – Healthcare decision-making and provider characteristic preferences among ethnic minority primary care elderly: results of the PRISM-E study - Maria Llorente, Julie Malphurs, Karen Cheal, U. Nalla Durai, Sue Levkoff, Betsy McDonel Herr, Eugenie Coakley, Hongtu Chen, Giuseppe Costantino, Cynthia Zubritsky, Karen Linkins, Chris Miller, Edwin Olsen, Jack McIntyre
- VA HSR&D 2002 – Suidical Thoughts Amongs Elderly Primary Care Veterans: Results from a Multi-site Study – Maria Llorente, Edwin Olsen, Eugenie Coakley, Susan Cooley, W. Van, U. Nalla Durai, JoAnn Kirchner, David Oslin, Dean Krahn
- VA HSR&D 2002 – Post-traumatic Stress Disorder in Elderly Veterans: Results from a Multi-site Study – U. Nalla Durai, B. Goodman, J.E. Kirchner,E.J. Olsen, E. Coakley, S. Bartels, M. Llorente, D. Oslin, W. Van Stone, S. Cooley
- GSA 2002 – Family Involvement: Protection Against Depression and Suicidal Ideation – Tracela M. White, Alan Regenberg, Mark Cary, Jim Coyne, Ira Katz, Cynthia Zubritsky, David Oslin

Published Articles:

- Suicidal and Death Ideation in Older Primary Care Patients with Depression, Anxiety, and At-Risk Alcohol Use – Stephen Bartels, Eugenie Coakley, Thomas Oxman, Giuseppe Costantino, David Oslin, Hongtu Chen, Cynthia Zubritsky, Karen Cheal, . Nalla Durai, Joseph Gallo, Maria Llorente, Herman Sanchez – in American Journal of Geriatric Psychiatry, 2002, 10: 417-427
- Design of a Multisite Randomized Trial to Improve Behavioral Health Care for the Elderly – Sue Levkoff, Eugenie Coakley, Herman Sanchez, Betsy McDonel Herr, David Oslin, Ira Katz, Stephen Bartels, James Maxwell, Edwin Olsen, Keith Miles, Giuseppe Costantino, James Ware – accepted for publication in 2004, Journal of Aging and Health

Submitted Articles:

- Managing suicide risk in late life: Access to firearms as a public health risk – David Oslin, Cynthia Zubritsky, Greg Brown, Marian Mullahy, Anthony Puliafico, Thomas Ten Have – submitted to American Journal of Geriatric Psychiatry
- Engaging Older Adults in Mental Health Services Through Primary Care: A Randomized Trial Comparing Integrated and Enhanced Referral Care for Depression, Anxiety, and At-risk Alcohol Use – Stephen Bartels, Cynthia Zubritsky, James Ware, Patricia Arean, Hongtu Chen, David Oslin, Maria Llorente, Keith Miles, Giuseppe Costantino, Louise Quijano, Jack McIntyre, Karen Linkins, Thomas Oxman, Sue Levkoff, James Maxwell – submitted to Journal of the American Medical Association
- Identifying Factors Critical to Implementing Integrated Mental Health Services in Rural VA Community-Based Outpatient Clinics – JoAnn Kirchner, E. Ansara, C.R. Thrush, M. Cody, G. Sullivan, C.G. Rapp – submitted to Journal of Behavioral Health Services Research
- Healthcare decision-making and provider characteristic preferences among ethnic minority primary care elderly: results of the PRISM-E study - Maria Llorente, Julie Malphurs, Karen Cheal, U. Nalla Durai, Sue Levkoff, Betsy McDonel Herr, Eugenie Coakley, Hongtu Chen, Giuseppe Costantino, Cynthia Zubritsky, Karen Linkins, Chris Miller, Edwin Olsen, Jack McIntyre – submitted to Journal of the American Geriatrics Society

Accomplishments Detail:

Monitoring and Evaluation

1. **Integrated/Referral Minimum Criteria.** The PRISM-E Study established a set of minimum criteria for each of the study models. These minimum criteria are designed to better test hypotheses for integrated and referral behavioral health service delivery models.

   There are three criteria to be considered an "integrated" site.

   - An integrated staff approach is used to provide MH/SA services provided by licensed mental health providers
   - Primary Care Providers (PCPs) are involved in mental health care of the consumer
   - MH/SA services are provided in the same clinic as primary care

   There are four criteria to be considered a "referral" site.

   - MH/SA specialist has primary responsibility for providing MH/SA care
   - MH/SA service delivery takes place at a specialty care setting which has certified mental health professionals and psychiatric expertise

- Referral to MH/SA specialty services should be made for all consumers in the referral arm
- Referral care system must be well-functioning, including written or verbal communication with the PCP

2. **Process Evaluation.** A Process Evaluation (PE) was conducted by each of the study sites. The purpose of the Process Evaluation (PE) is to collect a common set of organizational and system-level data elements across all study sites both referral and integrated. Items on the PE measured how clinics functioned, including staffing patterns, responsibility for care, physical and temporal proximity of services, and array of treatments offered. The data collected will enable assessment of the dimensions of integration and comparison of study sites. It will also help us to monitor compliance with the multi-site protocol and assess whether the sites' integrated and referral care models meet the minimum criteria established by the Integrated/Referral/Process Evaluation Committee.

3. **Site Visits.** The CC conducted site visits at various times throughout the project. There were seven goals for the site visits:
   - Assess site fidelity (i.e. whether integrated and referral care models meet a minimum set of criteria)
   - Provide technical assistance on an as needed basis
   - Gather information to refine the process evaluation
   - Test measures developed to assess fidelity
   - Assess model drift (between baseline and full implementation)
   - Identify barriers to project implementation
   - Conduct qualitative assessment of the factors influencing the implementation of integration

4. **Randomization and Data Collection System.** Another source of Consumer-level data was the randomization database. After participants were assessed as positive for a target condition, all of the SAMHSA sites and three of the VA sites randomized them to either integrated or referral care. The CC established a procedure for randomizing consumers into either the integrated of referral arms of the study. Sites with participants who were assessed positive for a target condition contacted the CC after assessment, and a member of the CC staff asked a number of questions regarding eligibility for the study. Once the consumer's eligibility was verified, the CC staff person referenced a randomization database which utilized permuted blocks in assigning consumers to either the integrated or referral arm of the study (giving each randomization an equal chance of being either integrated or referral). Once randomization occurred, either the research assistant (RA) at SAMHSA-funded sites, or a health technician (HT) at VA-funded sites, or a health care provider alerted the consumer of their assignment (this varied by site). The results from this process were stored in an Excel spreadsheet (access data table) and audited on a weekly basis. Weekly reports of multi-site study enrollment were circulated to study sites.

   - Process Data. In order to receive a random treatment assignment, the system reviewed the study inclusion and exclusion criteria with the RA/HT. This information exchange was important for both training and data quality purposes. These exchanges were also discussed during the weekly RA/HT conference call.

   - Outcome Data. The system collected the enrollee's age, target condition(s), and random treatment assignment. Tables describing, by site and overall, the age distribution, enrollment by target condition, and percent of projected enrollment attained were generated each week. These data allowed the CC and the Steering Committee to monitor whether the multi-site sample was balanced and whether our enrollment targets were met.

5. **Data Submission Tracking System.** Study sites submitted data to the CC on at least a monthly basis. When the CC received the study-site instruments, key variables (i.e. the ID, Consumer ID, RA ID, date

administered, and date received) were logged into an Access database. This allowed the CC to confirm and communicate with the sites the exact content of the data submission and allowed the CC to track the data as it flowed through the CC data collection system.

6. **Periodic Study Site Progress Reports.** The CC worked with the Planning Committee and the Steering Committee to develop a Study-Site Progress Report that all study sites submitted to the CC on a periodic basis. This report included information on site-specific enrollment, changes in integrated/referral care models, and staffing changes, as well as information on any publications or presentations that have been made relative to the study.

7. **RA/HT Conference Calls.** All research assistants, health technicians, interviewers, and Study Coordinators participated in weekly conference calls to discuss issues as they arose. This allowed the CC the opportunity to report on progress, discuss best practices in administering the multi-site protocol, and address any problems or issues that affected the multi-site protocol, particularly with respect to data collection and RA/HT performance.

Data Management

8. **Data Quality Assurance.** The production of high quality research data depends upon a strong quality assurance effort implemented by the CC and the individual sites. The CC developed a comprehensive plan for assuring data quality based on extensive experiences with the management of large, complex data sets. Elements included in this plan: regular contact with site research staff to review study procedures; programming extensive editing checks into the process of verification of scanned surveys (to look for missing or incorrectly coded data); programming via SAS to ensure that data from individual surveys are internally consistent and follow protocol guidelines (e.g., inclusion/exclusion criteria). Additional quality checks were needed to accommodate the VA-specific target condition of PTSD.

9. **Data Entry Program.** The Consumer-level data repository was developed utilizing a new generation of scanning technology called Teleform. Scanning is a fast process – the software and hardware have capacity to handle 2,000 double-sided pages an hour. This software and form reader (scanner) allowed study sites to submit completed screening, assessment, and treatment tracking forms to the CC with a minimum of processing. Sites were required to check data for completeness, bundle forms into sorted batches, and to copy forms for their records, but did not need to perform data entry, data file development, or extensive programming tasks.

   For the first several weeks of the project, sites were expected to send screening and baseline assessment data to the CC on a weekly basis, reverting to a monthly basis once programs became fully operational. Using Teleform, scannable surveys were designed by CC staff with logic built in so that scanned information from the written page was verified with an opportunity for interactive review of scanning decisions in fields that are incorrectly or questionably marked. When significant, repeated coding errors were identified, CC staff immediately contacted the sites and their operational staff to review coding procedures.

   A relational Access database was developed to track the flow of information to the CC. This database required additional customization to handle data issues specific to VA sites; for example the Little Rock site submitted data from a CATI system (Computer Assisted Telephone Interview) rather than paper Teleforms. An SPSS file was also developed to store consumer level data. Data were exported to these structures directly from the Teleform system after extensive data cleaning by CC staff. Each quarter, all of the eleven study sites received an electronic (SPSS or Excel) version of their sites' cleaned data.

10. **Data Repository.** The data repository of the multi-site study is being maintained at the CC. When completely implemented, it will consist of three core elements: consumer level databases, costs and claims

databases, and a project level database. The consumer level database will consist of a merged data set that includes information about individual socio-demographic characteristics, baseline and follow-up assessment data (target condition and severity, satisfaction, stigma, cultural issues, and functional outcomes). The cost and claims database will consist of all claims data identified by the cost study subcommittee of the steering committee. The project-level database will consist of qualitative characteristics of programs, participants, and contexts; including data on populations, treatment or service models and components, implementation problems, local environmental contexts, and evaluation methods. An analytic database was designed specifically for the process evaluation that can be used for statistical analyses.

Dissemination

11. **Prevention.** An annotated health literacy bibliography related to substance abuse and mental health in primary care has been completed and distributed to all participating sites. It was well received and we are now in the process of preparing a scientific journal publication based on the contents of the bibliography. Further, the CC prepared a talk on substance abuse prevention in the elderly for use by Center for Substance Abuse Prevention (CSAP) staff.

12. **GSA Symposium.** Through the work of the Publications Committee a symposium was organized for the 2000 Gerontological Society of America (GSA) conference in Washington D. C. The symposium involved a number of presentations, including an overview of the multisite study and a discussion regarding data from the first round of Process Evaluations. This symposium served to increase awareness among other investigators regarding the multisite project and its proposed goals. The Consumer Committee put together a Symposium for the 2001 GSA conference (see below).

Other accomplishments

13. **Provider Survey.** The Integrated/Referral/Process Evaluation Committee has developed a provider survey for purposes of the study. This survey was administered to both PCPs and MH/SA specialists involved in treatment during summer and fall 2001. The primary goals of the survey were: (1) to obtain providers' reactions to how effective communication is between PCPs and MH/SA specialists and the degree to which they share responsibility for care between them, and (2) to document provider perceptions of MH/SA care in integrated and referral models. The provider survey received approval from OMB in June 2001.

14. **Development of Inter-Agency Agreement.** Medicare claims data from CMS are an important resource for the existing cost study. CMS agreed to make a substantial in-kind contribution by making its data available at no cost, but did not support a full-scale cost study. Medicare claims files provide a consistent data source for outpatient and inpatient utilization across all of the SAMHSA sites. Medicare data are also the only source of claims for inpatient utilization at the SAMHSA sites. In addition, the files contain valuable information on out-of-system use for both VA and SAMHSA study patients. This information should be especially relevant to the VA cost study, since VA investigators have found previously that many veterans are using the VA and Medicare programs simultaneously.

15. **Consumer Committee.** Researchers and funders are realizing the value of actively incorporating consumer perspectives in research. Developing effective partnerships between consumers and researchers is challenging, but the benefits and opportunities are becoming clearer. This partnership development may be particularly true with older adult and ethnic minority populations. Consumers can help to enhance study subject recruitment, enrollment, retention, instrumentation, and other research procedures. They can also help to disseminate results to a broader, non-academic audience of policy makers, advocates, and the general public.

The Consumer Committee for the PRISM-E Study was formed in order to obtain valuable feedback from older adults functioning within the health care system. The involvement of consumers has added an important perspective to the development of the project, as investigators have been able to see how implementing certain policies and procedures may better serve the needs of participants in the study. The Consumer Committee has given feedback during the course of the project, and representatives attended the quarterly Steering Committee conferences where they both presented their recommendations and voted on key decisions. Each of the Study Sites has been required to develop their own local Consumer Advisory Committees that meet periodically to discuss the project and provide feedback on study issues, operations, and protocols. The multi-site Consumer Committee has also been involved in developing a "how-to" manual or tool kit that will assist similar programs or research efforts to develop their own consumer involvement programs.

Specific accomplishments of the Consumer Committee over the study period have included the following:

- Seniors-in-touch, a monthly conference call series that includes consumers and Principal Investigator from one of the sites as a guest. The calls have provided an environment in which consumers can talk to one another;
- Completion of a user-friendly Glossary of terms to help other consumers participate in MH/SA projects of a research or evaluative nature;
- Consumer-only preparation prior to the quarterly Steering Committee meetings, during which members of the Consumer Committee have drafted their recommendations to be implemented in the multisite study;
- Consumer communication with RA/HTs at the individual study sites, by which consumers have given feedback and advice in interacting with older adults;
- Quarterly progress reports, which have documented the progress of the Consumer Committee.
- Participation and commitment to developing academic articles and knowledge products independently and along with other multi-site investigators.

Targeted Capacity Expansion Program: Implementing Evidence Based Mental Health Services for Older Adults

Site Descriptions

La Clinica Del Pueblo, Washington, D.C.

Principal Investigator: Gloria Elliott
Program Coordinator: Jessica Moore
Program Evaluator: S. Lisbeth Jarama, Ph.D.

Target Population: Latino elders in the D.C. metropolitan area, primarily immigrants from Central and South America, especially the uninsured, underinsured, and impoverished.

La Clinica del Pueblo is a non-profit health clinic providing comprehensive health care, mental health care, and social services to Latinos of all ages, including the elderly population in the Washington, D.C. metropolitan area. In the past year, La Clinica has served on-site 100 elders for medical care and 30 for MH problems. EOFULA (Educational Organization of United Latin Americans) provides outreach, education and referrals, counseling and social services, case management, health screening, social activities, congregate meals, transportation, and translation services to elderly Latinos in the area. In the past year, EOFULA has served about 300 elders. Among them, 75 received counseling, and 10 received psychiatric care services provided by local mental health agencies.

One of the main goals for this project is to augment access to mental health and other services for Latino elders, whose need for them is presumably high but somehow are not being reached. Thus, in order to understand their situation better, La Clinica and EOFULA will conduct a needs assessment to identify unmet needs, what other services are required, and how families and consumers can help in the service delivery processes. The agencies will expand the mental health service capacity by increasing hours of current mental health clinicians/counselor and developing support group interventions. The agencies will also create an integrated model of care for the Latino elderly, which involves (a) training primary care providers to recognize mental health problems, (b) training mental health providers to recognize medical problems, (c) training peer counselors for outreach, and (d) providing psycho-education for consumers.

Kajsiab House, Mental Health Center of Dane County, Inc., Madison, WI

Principal Investigator: Linda Keys, MSSW
Program Manager: Doua Vang
Program Evaluator: Nancy Young

Target Population: Elderly Hmong refugees

Kajsiab House serves the Hmong community, providing mental health treatment and social services. It is unique in that its mental health treatment and social services takes place in the Hmong atmosphere, within the context of Hmong values and customs, and is conducted using the Hmong language. It treats primarily major depression, post-traumatic stress disorder, and anxiety.

Kajsiab House seeks to increase the number older participants (65+) and to make its services more culture- and age-sensitive for elders. This will include the addition of therapy and social groups for elders incorporating culturally appropriate activities, such as T'ai Chi and alternative healing methods and medicines. In addition, many older Hmongs require at-home care, and a mobile outreach capability will be developed to provide psychiatric and social services to homebound Hmong elders. Lastly, Kajsiab House seeks to develop and strengthen relationships between the Hmong community and the Aging and Physical Disabilities systems in Dane County, through collaboration between staff members and the Hmong; English and acculturation classes will be offered to the Hmong to facilitate this process.

Continuation and improvement in providing all treatment in ways taking into account customs, traditions, and beliefs of elders will be a hallmark of the project. This truly culturally competent service provision will improve the quality and accessibility of mental health services to Hmong elders.

HIPE: Health Improvement Program for the Elderly; Jewish Family & Children's Service of Southern Arizona, Inc., Tucson, AZ

Principal Investigator: Jane Singer
Program Coordinator: Peter Sanchez
Program Evaluators: Linda Phillips, Kristine Bursac, Sandy McGinnis, Elaine Rousseau

Target Population: Elders, caregivers, and family members in Pima County, Arizona representing Hispanic, urban Native American, and other minority populations.

The Health Improvement Program for the Elderly (HIPE) seeks to expand the services offered by the existing consortium of behavioral health providers of mental health services for the elderly that includes Catholic Social Services, Family Counseling Agency, and Marana Health Center. The consortium currently serves approximately 123 older adults and is so successful, that it can no longer meet the demand for services. Services include home and community based mental health and substance abuse prevention and treatment to elders.

HIPE will expand the provision of mental health and substance abuse services provided to elders, their family members, and caregivers. These services will also be modified in accordance with evidence-based practices to better serve program participants. Specifically, the program will provide home-based behavioral health services to 200 clients per year, and community-based behavioral health services to 300 clients per year. Educational presentations on the identification and treatment of behavioral health problems to 750 providers, case managers, and caregivers per year will be offered. Services will treat behavioral health concerns, including substance abuse, risk factors associated with mental illness or addictions, as well as offer bilingual services in Spanish. The HIPE Program will be culturally competent, with staff representing the diversity of the community.

Cottage Program, Tucson, AZ

Principal Investigator: Donna Wagner, M.S.
Program Evaluator: Maggie Allen
Project Coordinator: Evelina Marquez

Target Population: Elderly, many who are homebound, from diverse racial and ethnic backgrounds -- including American Indians and Mexican American -- and living situations, such as urban and rural dwellers.

Cottage currently serves over 120 adults, age 65 years and older, through its Elder Services Program. It provides a variety of much-needed services, including specialized case management that incorporates the physical and social needs of the client into their mental health treatment.

In partnership with the El Rio Santa Cruz Community Health Center and a rural behavioral health provider, Casa de Esperanza, Cottage will expand its Elder Services Program to provide mental health services to currently unserved Mexican American, American Indian and rural older adults in Pima County, Arizona. The program aims to reach out to the elderly community as well as to design more appropriate and effective mental health services for them. To address unmet mental health needs, Cottage will educate the community about behavioral health and aging, perform outreach activities, and conduct mental health screening. Their goal is to provide early intervention for mental health conditions, such as depression and anxiety disorders, and to thereby permit older adults to live more independently; concurrent screening and treatment will similarly take place for substance abuse conditions. Mental health services will be provided either onsite or in the elders' homes and will be integrated with primary health care; a case management model will be followed.

The proposed program will assess and build upon individuals' functional capacities and strengths, interests, cultural values and preferences, to better ensure positive outcomes. Consumers and family members will participate in the CEES Consumer Advisory Council, which will serve in an advisory capacity to the proposed program and will address policy and funding issues on behalf of older adults.

ElderLynk Expansion Program, Kirksville, MO

Project Director: Rene McGovern, Ph.D.
Assistant Project Coordinator/Data Specialist: Toviah Cain
Case Coordinator: Bridget Morton, R.N., C
Internal Evaluator: John Heard, Ph.D.
External evaluator: Robert B. Wallace, M.D.
Grant Assistant: Anita Franklin

Target Population: Older adults in northeast Missouri (ten counties).

ElderLynk was founded in 2000 and is a model rural mental health outreach program targeting underserved elderly persons age 65 and above. The ongoing goal of the ElderLynk outreach project has been to implement a locally accessible and seamless mental health delivery system that is well coordinated and integrated with primary care services. ElderLynk follows a case management/interdisciplinary team model for clinical services based on evidence from several research studies. It provides community education and awareness programs on mental health, as well as trains local health professionals and helps develop new models of mental health service delivery for rural older adults.

The ElderLynk Expansion Program will expand its service area to include two additional rural, underserved counties so that the elderly in ten counties of northeastern Missouri will gain access to mental health care. All rural patients over the age of 65 in targeted primary care clinics will be screened for mental health disorders, in a consumer-sensitive manner, and will be provided with appropriate treatment services, as necessary. To improve the quality of care and to increase awareness among health care providers of mental health conditions, professional education programs will be expanded to identify and develop "home-grown" mental health practitioners committed to the region. A faith-based outreach program will be implemented to enhance support within the community for those with mental illness, and consumers and their family members will be encouraged to provide feedback on and suggestions for mental health services. An integrated electronic medical record system and mental health treatment database will be designed to improve patient management. Services will be evaluated on an on-going basis to ensure continued service delivery improvements.

Senior Outreach Program, Unity Health System, Rochester, NY

Principal Investigator: Jack McIntyre, M.D.
Program Coordinator: Heide George, RN, M.S.
Program Evaluator: Thomas Zastowny, Ph.D.
Operations Coordinator: Laurie Naber
Manager, Primary Care Program: Susan Barrett, R.N.

Target Population: All elders with mental health needs in Rochester (including suburbs) and rural areas of Monroe County, New York

The Unity Health System currently provides integrated primary care and mental health services in twenty of its primary care clinics. Its Senior Outreach Program, which began in 1993, is supported by a United Way grant and provides a variety of supportive and mental health services in the community free-of-charge and serves about 65 clients at any one time.

This project will expand the services provided by the Senior Outreach Program to include more outreach, screening and assessment, and intervention as well as to serve a larger number of older adults. It is anticipated that the clinical team will serve over 300 individuals annually. Mental health assessment and evaluation, treatment, and support will be offered in a diversity of settings, including homes, primary care offices, and senior residences; case management will also be used to increase older consumers' access to mental health services. All interventions will be based on evidence-based practices, and the program aims to build an infrastructure for high-quality, continuous mental health care for the elderly. The interventions are further designed to provide accessible, non-stigmatizing care to elders, and afford the consumer an opportunity to select the most appropriate and comfortable treatment for him or her. Quality of care is also ensured through the provision of training and consultation with mental health specialists to primary care physicians and others treating mentally ill older adults.

Focus Project, City of El Paso, TX

Principal Investigator: Robert Salinas
Program Manager: Gabriela (Gaby) Martinez
Project Coordinator: Winifred (Freddie) Dowling
Project Evaluator: Jesús Sanchez, Ph.D.

Target Population: Homebound elderly (65+) receiving meals through a Nutrition Program.

The Focus Project of the City of El Paso expands mental health services to mostly lower income Hispanic seniors at high-risk for depression and dementia due to frail health and social isolation. The Focus Project will draw its participants from homebound seniors in El Paso who are receiving home-delivered meals through the City-County Nutrition Program. During the first year of the project 300 nutrition program participants will be screened for mental health conditions.

Seniors evaluated to have mild to moderate mental health conditions will be referred to the expanded Bienvivir Senior Health Services program, which will include mental health services for depression, anxiety and dementia. Bienvivir Senior Health Services, a PACE (Program of All-Inclusive Care for the Elderly) program, currently provides all-inclusive care to frail elderly in primary care settings. Eligibility for the program includes being medically needy of nursing home care. The care provided by Bienvivir addresses both medical and social needs and enables elders to live independently and safely in the community as opposed to in nursing homes. An interdisciplinary team assesses participants' needs, works with families to develop care plans, and delivers services in adult day health centers and at home. The Focus Project will increase Bienvivir's capacity to address mental health conditions.

Seniors who do not qualify for the PACE program or opt not to participate will be offered priority status, a Service Coordinator, and financial assistance to help them access, pay for, and adhere to treatment from El Paso's Community Mental Health and Mental Retardation Center (MHMR). The Focus Project will enhance MHMR's capacity to service older adults and access other aging services available in the community.

The Nutrition Program will monitor homebound seniors not in need of mental health services or not desiring services from Bienvivir and MHMR. Preventative services will be provided for this population to prevent or delay the onset of depression and/or dementia.

Lastly, the Focus Project will build a network among aging and mental health systems to increase outreach, integration and prevention. Training will be provided to staff in the area of mental health, long term care and other aging services, including cultural competency, and the City of El Paso will also convene and lead a Coordinating Council of various service providers and consumer representatives to address systems barriers and gaps encountered by seniors served by both the aging and mental health systems.

Tiempo de Oro Program, Valle del Sol, Inc., Phoenix, AZ

Principal Investigator: Jim Chavez
Program Coordinator: Ron Carpio
Prevention Coordinator: Elizabeth Stadick
Director of Prevention Services: Jerry Martinez
Program Evaluator: Anthony J. Alberta, Ph.D.

Target Population: Latino elders with mental health needs in Maricopa County, Arizona.

Tiempo de Oro is a new program led by Valle del Sol in Phoenix, Arizona. Partners include the Area Agency on Aging, Region One and ValueOptions the Regional Behavioral Health Authority in Maricopa County. The Tiempo de Oro project will target Latinos who are 65 years of age and older with mental health needs in Maricopa County, with the initial launch in the towns of Guadalupe and El Mirage, Arizona.

Valle del Sol will provide service capacity expansion activities that are based on successful practices. The Area Agency on Aging's ElderVention program will be expanded with adaptation of components for increased cultural competence. The preventative components of the ElderVention program that will be utilized by Tiempo de Oro are: (1) training aging service personnel on behavioral health aspects of aging (2) prevention education sessions at senior centers; (3) home-based prevention education; (4) outreach to identify isolated; at risk older adults; (4) telephone reassurance. Valle del Sol will add treatment services to this continuum to enhance the integrated preventative and treatment model of Tiempo de Oro. Further, various innovative outreach strategies will be implemented to address unmet mental health service needs in these areas.

Senior Behavioral Health Service Program, University of California, San Francisco, CA

Principal Investigator: Pat Arean, Ph.D.
Co- Principal Investigator: Sandra Lew, M.S.W
Lead Evaluator: Karen Linkins Ph.D.
Evaluation Manager: Rowena Nery, M.A.

Target Population: People 65 years of age and older living in residential facilities in Marin, San Francisco, and San Mateo counties, identified as needing depression and/or agitation management.

The SBHS is a community-based training, consultation and service delivery model based on the chronic-illness care model developed by the Institute for Healthcare Improvement (IHI). Residential care facilities include licensed Board and Care Homes, Assisted Living Facilities and Skilled Nursing Facilities, ranging in size from four beds up to 200 beds per facility.

The SBHS will expand its services to provide evidence-based prevention, early intervention and treatment of depression and agitation to elderly people living in residential facilities. Specifically, the program will (a) expand the existing program to create three SBHS teams to train facility managers to screen for mental health problems, to provide direct treatment services, and to train residential facility staff for managing depression and agitation; (b) create better coordinated service linkage between residential facility and health providers through SBHS; (c) provide outreach to facility staff and consumers and families by involving them in monthly care management meetings; and (d) conduct service evaluation.

Developments in Aging
National Institutes of Health
2001-2002

INTRODUCTION

Over the past several decades, research has shed considerable light on aging and health. It is now known that aging itself is not the cause of disease, disability, and frailty. Rather, it is disease and disabling processes influenced by age-related changes in the body and by unhealthy choices and sedentary lifestyles that are the most important factors in compromising the quality of life for older people. This fundamental shift in thinking was reinforced most recently with insights from the National Long Term Care Survey. According to this study, the rate of disability among older Americans dramatically declined from the 1980s through the mid 1990s, even among people age 85 and older. These findings, along with evidence from a number of clinical trials and studies, suggest more strongly than ever that disease and disability can be delayed or even prevented through specific interventions.

The challenge now is to maintain and even accelerate the trend in declining disability and to reduce rates of disease amid a steep rise in the number and proportion of older people. The task is urgent. Demographic projections show that the U.S. population is beginning to age at a rapid pace, with the first baby boomers turning 65 in 2011. Between now and the year 2030, the number of individuals age 65 and older likely will double, reaching 70.3 million and comprising a larger proportion of the entire population, up from 13 percent today to 20 percent in 2030 (1). Of great interest is the explosive growth anticipated among those most at risk of disease and disability, people age 85 and older. Their ranks are expected to grow from 4.3 million in 2000 to at least 19.4 million in 2050. The racial and ethnic makeup of the older population will change dramatically as well, creating a more diverse population of older Americans. These demographic factors combined threaten to increase the burden of age-related diseases and conditions on individuals, families, and society. Unless new understandings and interventions are developed and implemented to reduce disease and disability, the costs, in both human and financial terms, could be extraordinary.

Understanding the difference between advanced years that are active and independent and those that are characterized by frailty and dependence is at the heart of research supported by the National Institute on Aging (NIA), a component of the National Institutes of Health (NIH). The NIH is the principal biomedical research arm of the Federal government. The NIA, which was established by Congress in 1974, sponsors biomedical and behavioral research on the aging process and diseases and conditions affecting the elderly. NIA also leads the Federal research effort on Alzheimer's disease. Through independent, as well as collaborative, research efforts, the NIA and the other NIH Institutes and Centers are working to reduce disability and disease and promote healthy lifestyles for older people.

This report highlights a number of significant aging-related research advances and activities supported or conducted by the NIH in 2001 and 2002. Section I of this report outlines key

advances reported by the NIA for 2001 and 2002 in four major areas of research. Section II provides selected findings from other NIH institutes involved in aging research.

SECTION I

National Institute on Aging

The overall program of the National Institute on Aging is wide-ranging and includes research on the biochemical, genetic, and physiological mechanisms of aging in humans and animal models; the structure and function of the aging nervous system; social and behavioral aspects of aging processes and the place of older people in society; and the pathophysiology, diagnosis, treatment, and prevention of age-related diseases, degenerative conditions, and disabilities. Through its support of training programs, the NIA has provided critical tools to the next generation of investigators entering the field of aging research. In addition, the NIA has maintained a variety of programs, including the Alzheimer's Disease Education and Referral Center and the NIA Information Clearinghouse, to communicate the results of aging research and related health information to the research community, health care providers, patients, and the general public, providing guidance on health care, health promotion and disease prevention for older people.

Recent significant advances reported by the NIA are categorized here under four major headings: 1) Alzheimer's Disease and the Neuroscience of Aging; 2) Biology of Aging; 3) Reducing Disease and Disability; and 4) Behavioral and Social Research.

Alzheimer's Disease and the Neuroscience of Aging

Alzheimer's disease (AD) is a progressive, currently irreversible brain disorder. People with AD gradually suffer memory loss and a decline in thinking abilities, as well as major personality changes. These losses in cognitive function are accompanied by pathologic changes in the brain, including the buildup of insoluble protein deposits called amyloid plaques and the development of neurofibrillary tangles, which are abnormal collections of twisted protein threads found inside nerve cells. Such changes result in death of brain cells and breakdown of the connections between them. AD advances gradually but inexorably, from early, mild forgetfulness to a severe loss of mental function called dementia. Eventually, people with AD become dependent on others for every aspect of their care. The risk of developing AD increases exponentially with age, but it is not a part of normal aging.

AD is the most common cause of dementia among people age 65 and older and is a major public health issue for the United States because of its enormous impact on individuals, families, the health care system, and society as a whole. Scientists estimate that there are currently as many as 4 million Americans with AD, and annual costs associated with AD are estimated to exceed $100 billion. As the population ages, the numbers of people with AD and costs associated with increased prevalence could rise significantly.

Over the past three years, important progress has been made in our understanding of AD pathology, diagnosis, prevention, and treatment. Of particular interest is the completion of recruitment for the first NIH AD prevention trial, taking place at more than 70 sites across the U.S. This trial compares the effects of vitamin E and donepezil (brand name Aricept) in preventing the development of AD in people diagnosed with mild cognitive impairment, a population at high risk for developing AD. Further examination of estrogen and studies of various classes of anti-inflammatory drugs and antioxidants are also ongoing, and as scientists test these currently available medications, the next generation of drugs is being developed, targeting specific abnormal cellular pathways uncovered by recent discoveries, including plaque and tangle formation and death of brain cells.

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Identification of Risk Factor Genes for Late-Onset Alzheimer's Disease. Until 2001, just four of the approximately 30,000 genes in the human genome were conclusively known to affect the development of AD pathology. Three of these genes are associated with early onset AD, and only one is associated with the more common form of the disease, late-onset AD. Recent genetic studies suggest that as many as four additional and as yet unidentified genes may also be risk factors for late-onset AD. Finding new risk factor genes will help identify pathways affecting the development or progression of AD and may lead to better predictors of the disease even before it is clinically apparent.

Imaging Small Regions of the Brain in Humans and Genetically Modified Mice. Functional imaging, or the visualization of processes within the body in "real time," is potentially a useful tool for detecting changes in the brain that may suggest early AD, or for identifying markers that may indicate the extent of the disease. However, barriers to its optimal use remain. Traditional functional magnetic resonance imaging (fMRI), a common method for visualizing brain structures, allows imaging of structures a few millimeters in size, but no smaller. This resolution is insufficient for evaluating smaller structures, such as subregions of the hippocampus that are important to learning and memory. In addition, it requires that the person being imaged respond to specific instructions, an impossibility for many with cognitive impairments. A "new" method of fMRI has been developed that permits evaluation of these minute areas of the brain. This method, which is dependent on oxygen use in the brain during rest, does not require the person being studied to perform a mental task, making it easier to use among cognitively-impaired people. Although fMRI is currently available only in a research setting, these techniques could eventually be used to identify persons with loss of neurons in very specific brain regions — for example, in identification of persons at risk of AD.

Loss of Neurons in a Particular Brain Region is Associated with Onset of Cognitive Decline in Older Individuals. Participants in a recent study had detailed clinical evaluations within 12 months of death and were categorized as having no cognitive impairment, mild cognitive impairment (MCI—often a precursor of AD), or mild to moderate AD. At autopsy, people with MCI all had significant losses of neurons in the entorhinal cortex (EC) of the brain relative to those with no cognitive impairment, and these losses were as extensive as those in the patients with full-blown AD. In a second study, autopsies were done on people whose cognitive status

had been assessed shortly before their death. This study found extensive loss of neurons in the EC in people with very mild AD. In contrast, those with no loss of neurons in the EC, but with the AD hallmarks of plaques and tangles in their brains, showed no cognitive decline. These findings indicate that elderly people with MCI and very mild AD already have dramatic decreases in the number of neurons in a particular region of the EC, and that it is the onset of neuronal loss, rather than the development of plaques and tangles alone, that is associated with the onset of AD-related memory loss. This suggests that the development of interventions that will prevent, delay, or slow the degeneration of these critical neurons may be extremely beneficial to people at risk of AD.

Some People with Mild Cognitive Impairment (MCI) Progress to Alzheimer's Disease and Some Don't: How to Tell. Researchers evaluated people with MCI and, based on clinical findings, categorized their MCI as representing probable AD-related dementia, "incipient" AD-related dementia, or "uncertain" AD-related dementia. These volunteers were reassessed annually for up to 9.5 years, and at that time all the volunteers whose clinical findings had indicated probable AD-related dementia had developed the clinical symptoms of AD. However, many in the less severe groups had not. In another study, investigators categorized people as having normal cognition or having MCI or probable AD, both at entry into the study and at a subsequent clinical evaluation 2-4 years later. Each participant had an MRI scan at baseline and at follow up. The size of the hippocampus decreased in all groups, most rapidly in AD patients, less rapidly in those with MCI, and least in the control group. Within the control and MCI groups, those who experienced decline in cognitive function over time had a significantly greater decrease in hippocampal size than those who remained clinically stable. Previous studies have shown that baseline hippocampal volume can provide predictive information about which patients with MCI will decline to AD versus which will remain stable; together with this baseline information, serial measurements of hippocampal size through non-invasive MRIs may be a useful tool in the future for identifying people with MCI who will and won't progress to AD.

Environment May Protect Against Cognitive Decline and Alzheimer's Disease. Investigators hypothesized that recreational activities would be an excellent measure of mental activity, as these are less strongly influenced by economic and social factors than other risk factors for AD, such as the number of years of formal education. They recorded the extent to which 500 AD patients and age-matched healthy people had participated in recreational activities over their adult life. Patients with AD were found to have been much less active than healthy people of similar background in terms of both diversity and intensity of recreational activities engaged in during early and middle adulthood. These differences were not related to differing educational or income levels, age, or gender. People who were relatively inactive in midlife had a two and a half fold increased risk of developing AD. In a separate study, the relationship of social ties and support to patterns of cognitive aging over a 7.5 year period was examined in 1200 high functioning, community-dwelling adults aged 70-79. The results showed that greater baseline emotional support was a significant predictor of better-maintained cognitive function at the 7.5-year follow-up, controlling for known socio-demographic, behavioral, psychological, and health status predictors of cognitive aging.

The TAPP Mouse: The First Link Between Plaque and Tangle Formation. The neurofibrillary tangles (NFTs) that characterize AD are composed primarily of a form of the

protein called tau. In addition to NFTs, another key feature of AD is the deposition of beta-amyloid (Aβ) in insoluble amyloid plaques outside brain cells. The Aβ fragment is formed by clipping it out of the much larger amyloid precursor protein (APP). Although many scientists believe that excess production of Aβ is a root cause of AD, it is still unclear how this causes pathology. In particular, scientists do not understand whether excess production of Aβ leads to development of NFTs.

Now, a new mouse model may help us answer this question. A number of transgenic mouse models of AD have been developed by inserting human mutated APP genes into mice. Amyloid plaques, but not NFTs, form in these mice. A model for pathology of the tau gene has also been developed, but the NFTs in these mice do not usually form in areas of the brain that are vulnerable to AD. Scientists recently crossbred the tau mutant mice with the APP mutant mice to produce a new model, the TAPP mouse. The TAPP mice produce amyloid plaques; they also produce NFTs in regions of the brain that are vulnerable to AD, suggesting that APP or Aβ peptide can influence the regional formation of NFTs. This is the first animal model in which the elusive connection between amyloid pathology and tangle formation can be investigated. This improved animal model for AD may also be critical for success in developing therapies against NFT formation and the death of neurons in AD brain.

Pesticide creates a rat model of Parkinson's Disease. Parkinson's disease is a progressive neurodegenerative disorder characterized by selective death of neurons that make the neurotransmitter dopamine in a region of the brain called the substantia nigra. In an effort to develop a new model of Parkinson's disease, scientists exposed rats to rotenone, a common pesticide. Exposed rats showed pathological changes characteristic of Parkinson's disease, as well as motor behavior abnormalities, such as rigidity and decreased motor activity, that are frequently seen in Parkinson's disease patients. This new model of Parkinson's disease will be useful in designing and testing new therapeutic interventions, as well as further identifying environmental exposures that may be risk factors for developing the disease.

Promising Immune Treatment for AD. Using mice that were genetically engineered to produce Aβ and develop AD-like pathology in the brain, investigators found that treatment with an antibody that recognizes Aβ peptide results in clearance of Aβ plaques from the brain. Based on these findings, the investigators hypothesize that treatment with antibodies may be a useful and important approach for the treatment and prevention of AD and other neurodegenerative diseases.

Phenserine Regulates Translation of β-Amyloid Peptide Message: A New Target for Alzheimer's Disease Drug Development. AD's tell-tale amyloid β-peptide (Aβ) plaques are formed when a larger protein called amyloid precursor protein (APP) breaks down. Researchers are working to develop agents that reduce APP expression. In a recent study, investigators conducted laboratory tests of a drug called phenserine, originally developed to increase levels of the chemical messenger acetylcholine, which is depleted in the brains of people with AD. They discovered that phenserine inhibits APP formation in cells through a mechanism independent of acetylcholine. Current research is directed towards the design, synthesis, and development of agents that optimally and safely regulate APP and Aβ levels with the aim of slowing or halting the molecular events that lead to AD.

Statins May Reduce the Risk of AD. Evidence increasingly suggests that high levels of cholesterol may have a role in the development of AD. Two recent studies found that the use of statins, the most common type of cholesterol-lowering drugs, may lower the risk of developing AD. In a third study, transgenic mice fed a high cholesterol diet had much higher levels of blood cholesterol and the mean number of amyloid deposits in their brains (a hallmark of AD) was 65 percent higher than those on the normal diet. Taken together, these results suggest that statins – or dietary interventions – may be effective treatments or preventives for AD.

Imaging Enables Viewing Of Clearance of Plaques by Immunotherapy in Living Mice. Researchers have developed a powerful new imaging technique, multiphoton microscopy, which enables them to view changes in the brain caused by AD and subsequent changes induced by treatment. Multiphoton microscopy provides a resolving power 100 times greater than that of other non-invasive imaging techniques, and allows sufficient resolution to view very small structures and lesions in the brain such as plaques. In a recent experiment, antibodies specific for amyloid and labeled with a fluorescent dye were placed directly onto the surface of brains of anesthetized mice that had developed AD-like plaques. Using the new imaging technique, scientists noted reversal of existing amyloid-β deposits in the brain within 3 days of treatment with the antibodies. These findings demonstrate the potential effectiveness of antibody-mediated passive immunization for the removal of plaques from the brain.

BACE1 is the Major Beta-Secretase for Generation of Amyloid-beta Peptides in Mouse Brain. A major focus of study has been the process by which the amyloid precursor protein (APP) is clipped apart by enzymes to release **A**β fragments, which are then deposited in the brain as AD's characteristic plaques. A recently discovered enzyme that helps clip Aβ out of the APP protein was given the name β-secretase. In order to identify the enzyme that is responsible for production of Aβ in the brain, scientists developed a mouse model in which the gene for the BACE1 enzyme, a candidate for the active β-secretase, was selectively eliminated to see whether removing it would interfere with the clipping of APP to produce amyloid. Indeed, Aβ peptides were no longer produced in brain cell cultures made from the "knockout" mice, suggesting that BACE1 is responsible for the cleavage of APP into Aβ in the mouse brain. These findings will help in design of drugs to inhibit β-secretase activity, in hope of slowing plaque production. Furthermore, because the mice in which the BACE1 gene has been eliminated seem to develop normally, it may be possible to develop BACE1 inhibitors that interfere with Aβ deposition without negative effects on other metabolic pathways in brain or other tissues.

Depression and Agitation in Alzheimer's Disease: Effects on Caregivers. Previous research has examined the factors contributing to stress and depression in caregivers of an AD family member. A recent study found that the greater the level of depression in the patient, the greater the level of depression in the caregiver. Wives of AD patients and caregivers in poor health themselves were at particular risk for depression. This study demonstrates that the well-being of the caregiver and recipient are closely related, and suggests the need for interventions for caregivers early in the family member's illness.

Women Caring for a Family Member with Dementia Can Benefit from an Exercise or Nutrition Program. A one-year study involved 100 women age 49 to 82 years who were sedentary, free of cardiovascular disease, and caring for a relative with dementia. Participants received either a home-based, telephone-supervised moderate-intensity exercise training or nutrition education program. Exercise consisted of brisk walking for four 30- to 40-minute sessions per week. Compared with the nutrition education group, caregivers who exercised showed significant improvements in physical activity levels, stress-induced blood pressure reactions, and sleep quality. The nutrition group reported significant reductions in percentages of total calories from fats compared to exercisers. Both groups reported significant improvements in psychological distress, including depressive symptoms and self-rated stress level.

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Advances in AD Diagnosis. Recently, researchers have made progress in several areas related to early diagnosis of AD:

- **Tracking changes in brain metabolism.** Investigators in several recent studies have identified specific metabolic changes in the brain that are characteristic of AD, and in one study have demonstrated that measuring patterns of brain metabolic changes can be used to diagnose AD with a high degree of accuracy.

- **Tracking changes in brain structures.** AD is associated with changes in many brain structures. Investigators have found that atrophy of the hippocampus, a part of the brain affected by AD, is a sensitive marker of AD-related pathologic damage and changes in cognitive function. MRI measurement of hippocampal volume may be useful for identifying early AD or for assessment of cognitive decline.

- **Imaging and evaluating AD's unique pathologic features.** Researchers are developing new ways to view and track AD's characteristic amyloid plaques in the brain. In one study in mice, investigators developed a radioactive tracer that is attached to an antibody that binds to the plaques, enhancing the ability to image them. In another mouse study, researchers developed a dye-based compound that also binds to plaques, again facilitating imaging. Preliminary human studies using amyloid tracers have been described.

These and other techniques may also provide effective methods of tracking early AD changes in brain as well as treatment effectiveness, particularly through imaging amyloid burden in the brain.

Prevalence of cognitive impairment is high among a group of older community-dwelling individuals. Scientists are trying to determine the prevalence of cognitive impairment that is not dementia. Individuals with dementia are forgetfulness and have impairments in thinking, judgment, and the ability to perform daily activities. The condition called Mild Cognitive Impairment, or MCI, is not dementia, but it may be related to the eventual development of dementia and AD. Results from the first population-based study of cognitive impairment in the

United States, composed of 2212 African-American residents of Indianapolis, Indiana, ages 65 and older, indicate that 23.4 percent of the community-dwelling participants and 19.2 percent of the nursing home residents had MCI. The prevalence of cognitive impairment grew significantly with age, with rates increasing by about 10 percent for every 10 years of age after age 65. MCI was almost five times more common in the community than dementia. In addition, the scientists found that 26 percent of those characterized with MCI at the start of the study went on to become demented only 18 months later, although 24 percent of participants who were first diagnosed with MCI appeared normal after 18 months.

These results suggest that MCI may affect a significant proportion of older people. The factors that influence whether or not MCI will progress to dementia have not yet been defined. Whether the prevalence of MCI in the Indianapolis group is any higher or lower than other population groups is unclear, although the results appear to be consistent with the few studies done so far in other countries.

Neurons Know Where We're Going. Researchers are finding out the ways in which we spatially orient and maneuver ourselves in the environment. In a study of monkeys, they found that neurons in the brain's medial superior temporal area (MST) appear to encode information about direction of heading, path and place. These functions allow an individual to orient spatially in the environment. Since anatomical pathways from MST are associated with other brain areas that connect to the hippocampus (which is involved in AD pathogenesis), MST could play an important role in the spatial disorientation that is seen in AD and other neurodegenerative disorders.

Can Diet Affect Risk of AD and Dementia? Scientists increasingly believe that the answer to this question may be "yes." For example, researchers recently found that elevated blood levels of the amino acid homocysteine were associated with a significantly increased risk of AD. The association between homocysteine and AD was found to be strong and independent of other factors. Blood levels of homocysteine can be reduced by increasing intake of folic acid and vitamins B6 and B12; the use of these compounds is being explored in ongoing and planned clinical trials for the treatment and prevention of cognitive decline and AD.

NIH investigators are elucidating the mechanisms by which folate deficiency and elevated homocysteine can influence risk of neurodegenerative disease. In a recent study, they found that folate deficiency renders neurons in the hippocampus, an area of the brain critical to learning and memory, vulnerable to degeneration in a mouse model of AD. Additional studies showed that homocysteine increases the vulnerability of neurons to amyloid beta-peptide, a toxic protein whose organization into plaques is a hallmark of the condition. In a mouse model of Parkinson's disease (PD), folate deficiency resulted in increased damage to specialized neurons in an area of the brain called the substantia nigra, worsening motor dysfunction as a result. When infused directly into either the substantia nigra or striatum, homocysteine promoted neuronal degeneration and motor dysfunction. The researchers also determined the mechanism through which homocysteine endangers neurons: It promotes oxidative stress (cellular damage caused by molecules generated during normal energy metabolism) and impairs the repair of damaged DNA, thereby triggering a form of programmed cell death called apoptosis.

Active Lifestyle Generates New Neurons in Aged Brains. Human studies suggest that a mentally and physically active lifestyle gives some protection against developing dementia and neurodegenerative disorders, and a recent NIA-supported study suggests that this may be due to increased neurogenesis, or development of new neurons, in active individuals' brains. Investigators found that mice housed in an "enriched" environment (including exercise and play equipment) for up to 10 months showed a fivefold higher level of neurogenesis in the hippocampus (a brain area central to learning and memory) than mice housed in standard bare cages. "Enriched" mice also showed improvements in learning, exploratory behavior, and motor activity, and showed fewer lipofuscin deposits, an age-related indicator of neural degeneration, in hippocampal neurons.

Diabetes, ApoE°4 and the Risk for Alzheimer's Disease. Researchers evaluated the connection between type 2 diabetes, dementia, and APOE ε4 (the major AD susceptibility gene) in a large group of Japanese-American men. They found that participants with both type 2 diabetes and the APOE ε4 allele had a risk for AD which was 5.5 times higher than those with neither risk factor. At autopsy, participants with type 2 diabetes and the ε4 allele had a higher number of AD's characteristic amyloid plaques and neurofibrillary tangles in the hippocampus, the region of the brain where AD is thought to start. They also had a higher incidence of amyloid deposition in the blood vessels in the brain. Further investigation is needed into the underlying pathology and effects of treatment of diabetes on the incidence of AD.

A Tale of Two Proteins. Investigators engineered a fruit fly model that carried genes for human Hsp70 and alpha-synuclein, two proteins that when altered are implicated in the development of PD and other neurodegenerative diseases. Hsp70 is a chaperone protein, meaning that it aids in the proper folding of other proteins, and scientists are using this model to elucidate the roles of chaperone proteins in neurodegenerative diseases. Results to date suggest that finding ways to enhance and appropriately target chaperone proteins' activity may be an effective approach to treating neurodegenerative diseases such as AD and PD that are accompanied by altered protein conformation and aggregation.

Prions, Misshapen Proteins, and Out-Of-Shape Brains. Prions are infectious proteins that transform a normal cellular protein (PrPC) into an abnormal virulent form (PrPSc) that accumulates in the central nervous system, producing fatal neurological disease characterized by sponge-like holes in the brain that result in movement, emotional, sleep, and cognitive disturbances. These and other neurodegenerative diseases, including AD, PD, and Huntington's disease (HD), now are thought to be diseases of protein conformation in which a misfolded version of a normal cellular protein aggregates and causes neurodegeneration.

Investigators have made a number of advances in our understanding of prion diseases. In the first study, researchers noted that, although chemically the same, PrPC and PrPSc differ in structure. A fragment of the mouse prion protein with a single alteration that causes Gertsmann-Sträussler-Scheinker disease (a prion disease) can induce this disease in transgenic mice only if it is in the pathological form, indicating that prion proteins must exist in a particular structure to become infectious and produce neurodegeneration. The specificity of the prion structure may also limit transmission of prion diseases between different species: Researchers have demonstrated that breaching of the species barrier involves the generation of prions with

different structural templates that slowly accumulate over multiple transmissions in recipients. In another study, investigators identified a neurodegenerative disorder that mimics the symptoms of HD, but lacks HD's characteristic genetic mutation. Instead, the disorder is associated with mutations in the prion protein gene. Finally, researchers have found that, in mice, specially engineered antibodies can inhibit interaction between PrPC and PrPSc, which is necessary to PrPSc replication. In cells treated with the most potent antibody, prion replication was halted and existing prions were rapidly cleared, suggesting that the antibody may cure established infection.

Identification of Learning-Associated Genes in the Rat. The specific genes and proteins involved in the maintenance of long-term memory and learning remain largely unknown. NIH researchers recently trained rats in a maze, then used cDNA miroarrays – chips containing information from thousands of genes, which are electronically assessed and compared – to analyze the activity of genes known to be active in the hippocampus, a brain area central to learning and memory. They identified 18 known genes and 10 previously uncharacterized genes whose activity increased after the maze learning. These findings provide the groundwork for future, more focused research to elucidate the contribution of these genes in learning and memory processes.

Common Compounds May Be Effective Against Alzheimer's Disease. Recent research has suggested that use of several common, over-the-counter compounds may be associated with reduced risk of AD and dementia. For example, epidemiologic research indicates that there is a correlation between long-term use of non-steroidal anti-inflammatory drugs (NSAIDs), such ibuprofen and a reduced risk of developing AD. Several recent studies are consistent with the hypothesis that NSAIDs are effective against AD, in part through inhibition of inflammation-promoting cells within the central nervous system Clinical trials are necessary to test directly whether NSAIDs can prevent AD and dementia, and such trials are currently ongoing.

Likewise, researchers are developing new "antioxidant" drugs that ameliorate or prevent cell damage or death caused by oxidative stress, a form of cell damage caused by molecules generated during normal energy metabolism. Oxidative stress is implicated in a number of diseases, including AD and PD, as well as in normal aging. Recently, investigators tested the activity of three new compounds in mice lacking one form of a key antioxidant enzyme; the researchers found that the drugs increased the lifespan of the diseased mice by up to 3-fold and prevented harmful pathological and behavioral changes. Continued research on such antioxidant compounds may lead to new approaches to the treatment of AD, and perhaps other degenerative processes of aging.

Beneficial Effects of an Anti-Diabetes Hormone on Metabolism and Brain Function. Investigators have found that GLP-1, a gut peptide hormone that is present in the blood and that has generated interest as a potential treatment for type 2 diabetes, may have beneficial effects on brain functions. In a recent study, GLP-1 and its long-acting analog, exendin-4, stimulated the growth of nerve cells in culture. Moreover, GLP-1 and exendin-4 protected neurons in culture and in the brains of adult rats against injury and death in experimental models relevant to the pathogenesis of stroke and AD. Both prevented the loss of acetylcholine, a neurotransmitter that plays a critical role in learning and memory, and which is depleted in AD. These studies suggest

that GLP-1 and related peptides may be useful in reversing or halting the neurodegenerative processes that occur in disorders such as stroke and AD.

Supporting Caregivers of Persons with Dementia. The National Institute on Aging's REACH Project (Resources for Enhancing Alzheimer's Caregiver Health), a large, multi-site intervention study aimed at family caregivers of AD patients, was designed to characterize and test promising interventions for enhancing family caregiving. Nine different social and behavioral interventions and two types of control conditions (usual care or minimal support) were tested at six different sites, and 1,222 culturally and ethnically diverse caregiver/patient pairs participated in the study. The investigators found that the combined effect of interventions alleviated caregiver burden, and that active treatments that enhanced caregiver behavioral skills reduced depression. The results also show that subgroups of caregivers benefit in different ways from the same interventions. Women caregivers, Hispanic caregivers, non-spouse caregivers, and those with high school or lower education benefited significantly more from active intervention when compared to similar individuals in control conditions. These results indicate that individualized, but tested, caregiver interventions and the means to deliver them are critically needed. The second phase of the study, REACH II, has combined elements of the diverse interventions tested in REACH into a single multi-component psychosocial behavioral intervention and is ongoing.

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Stem Cells Help Repair Damaged Heart and Brain. In the mouse, stem cells show potential to replace cells lost in either the heart or brain. When primitive bone marrow cells (a type of stem cell) are injected into the mouse circulatory system, they can find their way to the damaged brain and gradually change into neuronal cells. When bone marrow cells are transplanted into mouse hearts damaged by a "heart attack," these cells regenerate not only new heart muscle but also blood vessel components. In mice, this repair can be accomplished in just a few weeks. In a recent, highly provocative study, mice in which heart damage had been induced were injected with cytokines (proteins) called stem cell factor (SCF) and granulocyte-colony-stimulating factor (G-CSF). Stimulated by the cytokines, primitive bone marrow cells swarmed to the damaged hearts, then converted to several different types of cardiac cells, contributed to repair of the damaged tissue and improved both the heart function and the survival of the treated mice. This finding, while preliminary, suggests that it may be possible to mobilize the body's own naturally-occurring stem cells to repair tissue damage and fight disease.

Gene Required for Full Reproductive Lifespan in Women. One to three percent of women have premature ovarian failure (POF), going through menopause before age 40. In a number of these cases, a mutant gene is likely to be the cause, but until now no gene directly involved in regulating the time of menopause in women has been identified. Recently, researchers isolated a gene, FOXL2, that is mutated in this condition. FOXL2 is required to activate a number of other genes in the ovary. When the function of FOXL2 is reduced, the number of follicles (eggs) in the ovary falls to a level too low to sustain a full reproductive lifespan. These findings reveal

the first gene that is critically involved in determining the number of follicles in a woman's ovary; as more is learned about FOXL2's function, interventions that prevent or alleviate POF may be developed. In addition, an understanding of the genes that affect premature menopause will help in understanding the normal menopause process and its consequences.

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Public Release of Novel Full-length Mouse cDNA Clone Collections. Arrays of DNA for specific genes permit the comparison of tens of thousands of genes at one time to determine which are turned on or off in a particular cell or condition. The NIA has assembled a collection of 7409 unique genes called the NIA mouse 7.4K cDNA clone set, which includes genes from various mouse stem cell lines, mouse early embryos, and mouse newborn organs. This set complements the existing NIA mouse 15K cDNA clone set, which has achieved international recognition as a unique and widely used resource. Like the 15K set, the 7.4K has been shipped to academic distribution centers for further replication and distribution throughout the research community. NIA scientists hope the immediate release of this additional high-quality DNA clone set to the scientific community will foster institutional collaboration and sharing of resources and speed the analysis of changes in the expression of many genes during aging processes.

A New Mouse Model of Accelerated Aging Provides Insights Into the Aging Process. NIA-supported investigators recently created a transgenic mouse carrying a mutation in the Xpd gene, which codes for an enzyme involved in both repair of DNA damage and transcription of DNA into RNA (an important first step in gene activation). This new model appears normal at birth but ages rapidly and lives only about half as long as normal mice. While not an exact model of premature aging, the new mouse model will be useful for studying a number of aspects of aging, including the roles of DNA damage and cell death, as well as the mechanisms through which the genome maintains itself and how such maintenance contributes to longevity.

Role of Telomeres in Cellular Senescence. Human cells have an inborn "counting mechanism" that tells them when to senesce, or stop dividing: Each time a cell replicates, the ends of each chromosome, called telomeres, get shorter, and once the telomeres get too short, they trigger a "senescence program" that arrests the cell's growth. Loss of telomere function can lead to genetic instability. Recent findings suggest that the senescence program is triggered by changes in the "protection state" of critically shortened telomeres, rather than their length -- in other words, the cell detects the likelihood that a shortened telomere will lead to genomic instability, regardless of the length of the telomere itself, and stops dividing as a result. Other findings suggest that the shortest telomeres in a cell become unstable and unleash the senescence program in order to avoid the propagation of genetically unstable cells.

Genetic Influences in Human Longevity. Researchers are beginning to identify biological and genetic mechanisms that might explain exceptional longevity. Using data from a study of families in which at least one member lived to be 100 or older, researchers recently found that siblings of centenarians had about half the risk of dying at every age throughout their lives

compared with people who did not have a centenarian sibling, and that brothers of centenarians were at least 17 times more likely to reach the age of 100 themselves and sisters were at least 8 times more likely to live at least a century. These findings are supported by research indicating that excess longevity (the difference between observed and expected length of life) is 15 percent heritable, and that the longevity of both siblings and more distant relatives may be predictive of one's own lifespan. Together, these findings point to strong underlying genetic components of longevity and provide an approach to mapping and identifying specific genes that may play a role in determining human longevity.

New Insights into Premature Aging Syndromes. Cockayne Syndrome-B and Werner Syndrome are devastating genetic disorders that cause accelerated and premature aging in affected individuals. The disorders are caused by mutations in the CSB and WRN genes, respectively. NIH researchers continue to elucidate the mechanisms through which the CSB and WRN genes operate, and have found that each gene is involved in DNA clean-up and repair. Recently, they found that the protein associated with the CSB gene has a role in repair of DNA damage caused by oxidative stress (cellular damage caused by molecules generated during normal energy metabolism). The protein associated with the WRN gene facilitates the activity of another protein, FEN-1, which is critical to DNA replication and repair. In fact, WRN stimulates FEN-1 more dramatically and efficiently than any other known protein. WRN also interacts with the tumor suppressor p53. The researchers conclude that mutations in the WRN gene may lead to premature aging and cancer susceptibility through dysfunction of the coordinated action of WRN protein, p53, and FEN-1 in a complex DNA repair process. These findings may suggest potential target molecules for the treatment of Werner Syndrome and Cockayne Syndrome-B, or even regulation of the aging process.

Nitric Oxide Controls the Strength of the Heart Beat. The heart is the body's most powerful muscle; its fibers stretch and contract to form the heartbeat. During periods of stress, including physical exercise, blood is pumped more rapidly throughout the body, and heart muscle stretch increases in response. Stretch also affects contraction strength; when heart muscle fibers stretch, calcium ions, which regulate contraction, are released from a part of the fiber called the sarcoplasmic reticuluum (SR). The efficiency of this process is critical to the quality of life during periods of good health, as well as during periods of disease. NIH researchers have found that heart muscle stretch activates a particular pathway that generates nitric oxide (NO). NO, in turn, enhances the fibers' capacity to release calcium ions from the SR. When the stretch is increased, as in periods of physical exertion, NO release is increased, strengthening the contraction. This mechanism could determine an important part of intrinsic cardiac reserve capacity. In addition, the researchers hypothesize that the loss of naturally occurring NO mechanisms in the body could contribute to the development of functional impairments of heart muscle when other compensatory mechanisms fail.

A Pharmacological Intervention to Delay Aging in Fruit Flies. Using animal models, researchers are identifying possible pharmacological interventions that might be useful in delaying aging in humans. In a recent study, fruit flies fed the chemical 4-phenylbutyrate (PBA) throughout adulthood lived significantly longer than average, with no negative effects on physical activity, stress resistance, or fertility. The investigators found that two genes that became overactive in response to PBA treatment code for specific proteins that could have an

impact on longevity; thus, these results also suggest a new approach in the search for genes that may play a role in longevity regulation. More research is needed to determine whether PBA treatment of other animals also affects their longevity.

Adult Neural Stem Cells Make Functional Neurons. The generation of new functional neurons from neural stem cells (neurogenesis), either from those present in the brain or from those transplanted into the brain, could be harnessed to regenerate damaged brain tissue, to replace dying neurons, or to enhance the ability of the brain to respond to age-related impairments. Adult neurogenesis occurs in the hippocampus, a brain region important for learning and memory, which shows degenerative changes in aging and AD. Although the new cells resemble mature neurons, until recently it was unclear whether the new neurons are functional or integrate into existing neural circuits.

Two studies now show that neural stem cells in the adult hippocampus develop essential properties of functional neurons. In the first study, investigators labeled stem cells in the hippocampus of adult mice by tagging them with a protein called GFP. When the hippocampus was examined 2 days after the injection, the GFP-labeled cells looked like immature neurons, whereas by one month the GFP-labeled cells looked and behaved like authentic hippocampal granule neurons. Close examination showed that the new neurons had properties similar to their mature neighbors, and that they received input from other cells. In the second study, researchers isolated stem cells from the hippocampus of adult rat brain and then tagged the cells with the GFP protein. When these tagged stem cells were cultured along with normal hippocampal neurons or astrocytes, support cells that foster neuron growth, they formed neurons with axons and dendrites, which are structures critical for communication with other cells. In fact, these stem cell-derived neurons made functional connections, called synapses, with normal hippocampal neurons and with each other, and released neurotransmitters, the chemical mediators of neuronal communication.

Isolation of Neuron-Restricted Precursor Cells from Human Embryonic Stem Cells. Cells in the brain and central nervous system differentiate through a multi-step process. As development progresses, stem cells – cells with a unique capacity to regenerate and give rise to many tissue types – generate a class of cells known as precursors or progenitors, which in turn generate the highly specialized cells of the brain and nervous system. Scientists now have the ability to isolate human embryonic stem (hES) cells, and have found that hES cells proliferate and maintain their pluripotency (ability to give rise to different tissue types) in cell culture. NIH researchers have recently developed a method for inducing hES cells to differentiate into neural progenitor cells and neurons. The newly-derived cells exhibit the appearance and properties of cells ordinarily found in the brain and central nervous system. These data indicate that hES cells could provide a source for neural progenitor cells and mature neurons for therapeutic and toxicological uses.

Reducing Disease and Disability

Chronic disease and disability can compromise the quality of life for older people. Some 79 percent of people age 70 and older have at least one of seven potentially disabling chronic conditions (arthritis, hypertension, heart disease, diabetes, respiratory diseases, stroke, and

cancer). The burden of such chronic conditions poses a challenge to individuals as well as families, employers, and the health care system. Research to improve understanding of the risk and protective factors for chronic disease and disability can lead to the development of effective prevention strategies. This section describes some of the latest findings on the treatment and prevention of various age-related diseases, as well as the molecular underpinnings of disease.

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Comorbidity and Breast Cancer in Older Women. Most breast cancer and related deaths occur in women aged 55 years and older. Concurrent age-related health problems such as hypertension, heart disease, diabetes, chronic obstructive pulmonary disease, and cerebrovascular disease are likely to affect the course of the disease and treatment options. Researchers have found that older breast cancer patients with preexisting health conditions receive less aggressive pretreatment assessments and cancer treatment than younger, healthier women. Given the high incidence and mortality rates of breast cancer in older women, research is needed to determine how age differences and accompanying health problems should guide assessment and treatment choices.

Low-Dose Estrogen Reduces Bone Breakdown in Older Women. More than 100 women over the age of 65 participated in a study of three different doses of estrogen therapy. The highest of these doses was the amount most commonly used today in estrogen replacement therapy, and the lowest dose was one-fourth this amount. The participants were studied for 6 months: 3 months on treatment and 3 months off. The low dose markedly reduced bone breakdown as measured by several serum markers, a reduction that was similar to that produced by the highest estrogen dose. Breast tenderness, bleeding, and thickening of the lining of the uterus (an indicator of potential adverse uterine effects) were significantly less frequent with the lowest dose. In fact, low-dose therapy resulted in no more side effects than placebo. These findings suggest that a lower dose of estrogen may be just as effective as the regular dose, but have fewer side effects.

Persistence of Cognitive Decline after Coronary Artery Bypass Surgery. One of the more common types of surgeries performed in the elderly is coronary artery bypass grafting (CABG). CABG may have adverse effects on the brain including stroke, post-operative delirium, and short-term cognitive impairment. Until recently, it was believed that most cognitive decline after CABG surgery is transient. However, researchers have now found that among older individuals undergoing CABG surgery, cognitive function at discharge may predict long-term cognitive function. Following a group of 261 CABG patients, the researchers found that over half exhibited some cognitive decline at discharge. The patients, as a group, went on to show a pattern of early improvement at 6 weeks and 6 months. At the 5-year assessment, however, some 42 percent of the surgery group was performing below baseline cognitive levels. Additional predictors of later decline included older age at surgery and lower level of education. Perioperative injury, increased susceptibility to injury, or decreased ability to recover from injury, may be responsible for cognitive dysfunction after CABG surgery and will be important research issues to pursue.

Physical Exercise Prevents Disability in Older People with Arthritis. Older people with osteoarthritis of the knee often have difficulty doing basic activities of daily living (ADLs), including walking, eating, dressing, using the toilet, bathing, or even moving from bed to a chair. Although previous exercise interventions have shown positive effects, none has yet been shown to affect clinically significant outcomes such as ADLs. Researchers recently conducted a study of exercise in 250 community-dwelling people, 60 years of age or older, with knee osteoarthritis. The participants were divided into 3 groups. Two groups participated in either an aerobic exercise program to increase endurance, or a resistance training program to increase strength. The third group did not participate in structured exercise programs and served as a control group. ADL disability was measured every 3 months throughout the 18 months of the study. Participants in both exercise programs had lower incidences of ADL disability than those in the control group. Individuals who complied most diligently with the exercise program had the lowest risk for disability. These results suggest that regular exercise has great potential to prolong the independence of older people despite the presence of this common and often disabling disease.

Reducing Delirium after Hip Fracture in Older Adults. Delirium, an acute confusional state, complicates recovery from hip fracture repair in at least one-third of the 250,000 older Americans who fracture a hip each year. Besides being frightening to patients and their families, and difficult to manage in the hospital, delirium after hip fracture is also associated with poor recovery of function. In a recent study aimed at reducing risk factors for delirium, geriatricians provided a variety of recommendations to the orthopedic physicians caring for the hip-fracture patients. These recommendations included transfusing blood to maintain an adequate red blood cell count, limiting the use of psychoactive medications, and providing adequate pain management. This intervention led to a one-third reduction in patients who developed delirium and a one-half reduction in the proportion of patients who developed severe delirium compared to a control patient group. This study demonstrates that measures can be taken to prevent delirium in vulnerable older patients.

Dietary Restriction Increases Levels of Growth Factors in the Brain and Stimulates Production of New Nerve Cells. Reducing calorie intake (dietary restriction, or DR) can increase the lifespan of rodents, and can also promote resistance of rodents' brain cells to injury. The cellular and molecular mechanisms responsible for the beneficial effects of DR on the brain are unknown. In a recent study, adult rats and mice maintained on a DR feeding regimen for 3 months showed increased levels of the neuronal growth factor brain-derived neurotrophic factor (BDNF) in the hippocampus, a brain region involved in learning and memory, as well as in several other brain regions. The rats also exhibited a significant increase in the numbers of newly divided cells in a region of the hippocampus. These findings provide the first evidence that diet can affect expression of a neurotrophic factor and can also stimulate the production of new neurons in the brain; they may also help to explain the beneficial effects of DR on learning and memory in animals, and may have implications for developing new ways to combat age-related neurodegenerative disorders.

Working to Cure Prion Diseases. Prions are infectious proteins that alter the shape of a normal cellular protein, changing it into a prion. They can cause several rare but invariably fatal neurodegenerative disorders, including Creutzfeld-Jakob disease (CJD). Investigators have used

a number of approaches to identify compounds that are effective in clearing prions from cells in tissue culture. Two drugs, quinacrine (an anti-malarial drug) and chlorpromazine (an anti-psychotic drug), are known to enter the brain and are among the compounds that cause the clearance of prions in tissue culture. These compounds were effective at non-toxic concentrations and have been used for many years in humans, making them likely subjects for clinical trials to test their efficacy in treating people with CJD who otherwise face certain death.

Potential New Treatment for Type 2 Diabetes in the Elderly. Type 2 diabetes mellitus is the most common form of diabetes among the elderly. It occurs when pancreatic beta cells produce insufficient insulin or when the body cannot use its insulin efficiently. GLP-1, a gut peptide, can stimulate beta cells to produce more insulin in middle-aged people with type 2 diabetes. However, until recently it had not been tested in older adults, who make up the majority of patients with the disease. Recent studies showed that GLP-1 potently stimulated insulin release in elderly people with diabetes and lowered blood glucose to normal levels. In parallel studies with elderly rodents, investigators found that when GLP-1 was given long-term, it increased the number and activity of pancreatic beta cells. Researchers are now developing longer-acting forms of GLP-1 and have begun longer-term trials of GLP-1 treatment in an elderly population.

A Large-Scale Analysis of Gene Expression in Ovarian Cancer Suggests Possible Targets for Early Detection and Treatment. Ovarian cancer is the fifth most common cause of cancer death among women in the United States, yet it is very poorly understood. Ovarian cancer affects older women disproportionately. Because there are few early symptoms, and no sensitive screening tests for use in the general population, it is typically diagnosed in late stages, when treatment is difficult and often unsuccessful. More detailed knowledge of gene expression in ovarian cancer is crucial to a better understanding of how ovarian tumors form and to identifying novel targets for diagnosis and therapy. Serial Analysis of Gene Expression (SAGE) is a powerful method for analyzing the genes expressed in any cell or tissue. Researchers developed SAGE libraries representing the genes active in various normal and neoplastic ovarian tissues and identified many genes that were expressed differently in normal ovary and in ovarian cancer cells. The genes identified by this method have the potential to become useful targets for early detection and therapy. In addition, this work provides a framework for a detailed understanding of how ovarian tumors form at the molecular level.

Integration of Aging and Cancer Research. Cancer is largely a disease of the elderly. However, much remains unknown about cancer diagnosis, prevention, and treatment in older people. NIA and the National Cancer Institute (NCI) have created a partnership that has resulted in support for a number of projects. Ongoing initiatives include joint program announcements and the inclusion of NIA-supported studies within the NCI Cooperative Group system (a network of consortia throughout the U.S. that collaborate frequently on clinical trials for a variety of common cancers). Recently, the NIA and NCI extended this collaboration to NCI's Cancer Centers program, which is composed of 60 major academic and research institutions that sustain broad-based, coordinated, interdisciplinary programs in cancer research. A joint workshop was held in June 2001, and an aggressive research agenda within the NCI-designated cancer centers is now developing that can reduce the burden of cancer for older persons.

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Beneficial Effects of an Anti-Diabetes Hormone on Metabolism. New studies show that GLP-1, a gut peptide hormone that is present in the blood and that induces secretion of insulin from the pancreas, has beneficial effects on cellular absorption of glucose among people with insulin resistance, a prediabetic condition. In one study, GLP-1 increased glucose uptake among insulin-resistant people over age 70 in whom insulin secretion had been artificially suppressed. The investigators also found that, in young people who were severely insulin resistant due to obesity, administration of GLP-1 brought their glucose uptake capability into line with that of their lean counterparts.

Bisphosphonates May Combat Glucocorticoid-Induced Bone Loss. Glucocorticoids, often used to treat a variety of conditions that arise in the elderly, cause a rapid and marked decrease in bone mineral density, making a population that is already susceptible to osteoporosis even more subject to bone loss. Common treatments for osteoporosis, such as calcium, vitamin D, or fluoride, are not very effective against glucocorticoid-induced bone loss. A class of drugs, known as bisphosphonates, does show promise as a possible treatment. Now, NIH-supported researchers have dissected the individual actions and the interactions of glucocorticoids and bisphosphonates on bone. This work demonstrates that each of these drugs tips the balance between bone formation and bone resorption in mice in both an early and later phase. The early phase of bone resorption caused by glucocorticoids cannot be counteracted by bisphosphonates, but in the longer term this balance shifts as bone-resorbing cells die and the lifespan of bone-building cells is extended due to bisphosphonate treatment. Understanding how bisphosphonates work has direct implications on the treatment of osteoporosis, a common condition among older Americans, and other diseases and conditions involving bone loss.

Structured Restorative Home Care Produces Better Health and Function After Acute Illness and/or Hospitalization in Older Persons. Illness and hospitalization often initiate functional decline in older persons, and this decline can often persist long after the acute episode is over. An increasing number of older persons receive home care services after such episodes. In a recent NIA-supported study, patients on a "restorative care program" were significantly less likely to need rehospitalization, nursing home placement, or emergency room care after hospitalization as compared to people receiving "usual" home care. The restorative home care program consisted of the establishment of integrated teams of nurses and other health professionals and the application of structured interventions for disabilities, including exercises, behavioral changes, environmental adjustments and adaptive equipment, medication adjustments, and patient and family education. Functional abilities for living at home such as preparing meals, using transportation, shopping, doing laundry, and taking medicines appropriately were also significantly better in the restorative care group, as was mobility.

Benefits and Costs of Cervical Cancer Screening into Old Age. Although mortality rates for cervical cancer have declined substantially because of widespread use of Papanicolaou (Pap) screening, the test may fail to detect cancer. An increased understanding of the role of human papillomavirus (HPV) infection in the development of cervical cancer and advances in technologies for HPV detection have prompted exploration of HPV testing as an adjunct or

primary screening tool. As with many common conditions, a critical public health issue regarding HPV screening is the cost-effectiveness of screening persons of all ages versus setting an upper age limit for screening.

Researchers constructed a model based on U.S. cervical cancer incidence, current screening rates, accuracy of diagnostic tests, and effectiveness of treatment, to examine the cost-benefit ratios of different population screening strategies every two years or every three years -- joint Pap and HPV testing, Pap testing alone, and HPV testing alone. The benefits of screening were measured by the gains in years of survival adjusted for the absence or presence, and severity, of cervical cancer. This model was used to estimate cost-benefits of the different strategies for women beginning at age 20 and continuing to either age 65, to age 75 years, or death. They found that the greatest benefits of screening came from combined Pap and HPV testing every two years through death, with only a modest increase in cost above Pap screening alone. 98 percent of the benefits were retained if an upper age limit of 75 was set for screening. However, the proportion of the benefits retained was substantially lower (87 percent) if the upper age limit was set at 65.

Age Does Not Influence the Response to Resistive Strength Training. Loss of muscular strength and muscle mass with age (sarcopenia) is associated with the development of disability and frailty in the elderly. Men and women in two age groups – 20-30 and 65-75 – participated in a resistive strength training program. Both age groups increased strength, showed similar increases in muscle mass, and showed similar increases in resting metabolic rates, which generally decrease with age.

A Drug to Improve Bone Marrow Transplant Success. In an allogeneic bone marrow transplant (BMT), in which the recipient receives bone marrow from a donor, the recipient must be given drugs that suppress the immune system in order to prevent the body from rejecting the transplant. Immunosuppressive drugs commonly used with BMT patients include Cyclosporin A (CsA) and FK506, which are also used to treat a number of autoimmune diseases. However, these drugs have a limited success rate; the body resists their activity through a specific molecular pathway. NIH researchers have demonstrated recently that the immunosuppressive drug rapamycin, an antibiotic, blocks this pathway, suggesting that the success of immunosuppressive therapy in allogeneic bone marrow transplantation and autoimmune disorders could be improved by combination treatment with CsA/FK506 and rapamycin.

Lifestyle Change and Medication Can Prevent Type 2 Diabetes, but Efficacy of These Interventions May Vary by Age. NIA provided support for researchers participated in the Diabetes Prevention Program, a major, multi-institutional study that was initiated by the National Institute on Diabetes and Digestive and Kidney Diseases and was designed to identify interventions that could prevent or delay the development of type 2 diabetes. The researchers found that people who are at high risk for diabetes can sharply reduce their risk losing weight with a reduced-fat, low-calorie diet and moderate exercise regimen. This effect was most pronounced among study participants age 60 and over. Treatment with the drug metformin (Glucophage®) also reduced diabetes risk among study participants, but for unknown reasons was less effective among older participants. Nearly half of the study participants were members

of racial and ethnic groups that suffer disproportionately from type 2 diabetes, including African Americans, Hispanic Americans, Asian Americans and Pacific Islanders, and American Indians.

Old Immune Systems are Less Responsive to New Infections. The immune system becomes less effective as we age, and this loss of function contributes to illness and death in the elderly. B cells, or specialized white blood cells that produce antibodies against invading pathogens, are critical to the immune response, but their role in the aging immune system is not yet well understood. Researchers have observed that subsets of B cells respond to each new infection by producing antibodies that react specifically to the infectious agent. These "experienced" B cells are then highly effective at responding to re-encounter with the original infectious agent, but are less able to respond to new infections. The body also produces "naïve" B cells that are capable of tailoring their response to new infections, but as people age, fewer new B cells are produced. In a recent study, NIH-supported investigators closely examined B cells in young and elderly mice and found that the aged mice have much higher levels of experienced, as opposed to naïve, B cells when compared to younger mice. They suggest that the experienced B cells are retained in the body as a result of chronic stimulation from the environment. This is correlated with a decline in generation of new B cells in the bone marrow, with the consequence that the overall immune response is less effective for new infections.

Lipid Abnormalities Linked to Lou Gehrig's Disease. NIH investigators have identified severe abnormalities in the metabolism of cholesterol and of sphingolipids, a type of fat, in the spinal cords of amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease) patients and in mice that have been genetically engineered to manifest symptoms of ALS. These abnormalities result in the production of increased levels of sphingolipid byproducts and accumulation of cholesterol which prove toxic to motor neurons at high levels. In mice, the appearance of metabolic abnormalities precedes the development of symptoms, suggesting that the abnormalities have a role in killing the neurons. The researchers also found that drugs that rein in sphingolipid synthesis can prevent the accumulation of toxic byproducts and thereby protect motor neurons from damage. The ability of a drug that prevents accumulation of sphingolipids and their byproducts to protect motor neurons suggests that this and related drugs, as well as modifications of dietary intake of fats, may reduce the risk of ALS.

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Positive Emotions in Early Life Linked to Longevity. Findings from the Nun Study, a longitudinal study of Alzheimer's disease and aging that follows the lives of older members of a religious order in the United States, indicate that positive emotional content in early life autobiographies was strongly associated with longevity six decades later. Nuns who expressed more positive emotions in their autobiographies lived significantly longer than nuns expressing fewer positive emotions. Finding such a strong association between written positive emotional expression and longevity indicates a need for research that sheds light on the underlying mechanisms responsible for and associated with this relationship.

Personality Determinants of HIV Risk Perceptions and Behavior Changes. Eleven percent of people with AIDS in the United States are over age 50. A recent study conducted in an economically disadvantaged and high-risk group suggested that personality traits are associated with perceptions of risk for HIV. The investigators also found that individuals who believed they were at high risk for being infected with HIV were no more likely to increase condom use after a four-session risk reduction intervention than those who thought they were at low risk. However, individuals who showed greater conscientiousness and those who had a stronger sense of their own competence and ability to control their own behavior were more likely to adopt condom use. These findings provide insight into high-risk sexual behavior among older Americans and may help us develop interventions that modulate them.

Home Medical Devices Are Not As Easy As 1, 2, 3 for Older Adults. Advances in medical technology are enabling individuals to take a more active role in their own health care. For example, hand-held, battery-operated devices called glucometers enable people with diabetes to monitor their own blood glucose levels. However, an analysis of several currently available blood glucose monitoring systems showed that they are quite complex and provide little feedback on whether they are being used correctly. The analysis revealed that the typical system requires over 50 steps for blood monitoring and system calibration. Further, existing instructions were inadequate for teaching new learners how to use this complex technology; the written instructions were beyond the reading comprehension level of 60% of the general population. These results indicate that human factors research with older adults, design changes to improve usability, and careful training are required to ensure safe and appropriate use of new technologies and to enhance the self-care strategies of current medical practice.

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Personality and Risky Behaviors. A recent study examined relationships between a comprehensive measure of personality, the Revised NEO Personality Inventory, and condom use and other HIV risk behaviors. Participants consisted of 201 disadvantaged, primarily African-American participants of an HIV risk reduction program. Participants were divided into three risk groups (high, medium, and low risk) based on their self-reported sexual history, sexual

behaviors, and intravenous drug use with shared needles. Results indicated that high-risk behavior was associated with emotional distress, poor self-control, and hostile and antagonistic attitudes and behaviors. The high-risk group demonstrated less ability to resist cravings and urges than the medium- and low-risk groups. The high-risk group also scored lower on measures of feelings of self-efficacy, motivation to carry tasks through to completion, and aspiration levels. All participants, regardless of risk classification, scored within the average range on measures of excitement-seeking. These results suggest that individuals who engage in high-risk sexual behaviors are motivated less from a desire for "thrills" than for temporary relief from psychological suffering. Successful intervention in these AIDS-related behaviors may require interventions tailored to at-risk individuals' basic tendencies.

Disentangling the Relationship Between Education and Health. There are large differences in health outcomes by socioeconomic status (SES) that cannot be explained fully by traditional arguments, such as access to care or poor health behaviors. Researchers recently considered a different explanation—better self-management of disease by the more educated. They examined differences by education in treatment adherence among patients with two illnesses, diabetes and HIV, and then assessed the subsequent impact of differential adherence on health status. After controlling for other factors, more educated HIV+ patients were more likely to adhere to therapy, and this adherence made them experience improvements in their self-reported general health. Similarly, among diabetics, the less educated were much more likely to switch treatment, which led to worsening general health. The investigators conclude that, among patients with diabetes or HIV, higher educational status is correlated with the ability to maintain a complex health regimen, which in turn is directly linked to subsequent health outcomes.

Involvement in Caregiving and Adjustment to Death of a Spouse. In a recent study, NIH-supported researchers evaluated 129 people, ages 66 to 96, whose spouse had died during a four-year period. Participants were classified as noncaregivers, caregivers who reported strain related to their caregiving activities, or caregivers who reported no caregiving-related strain. The researchers assessed the participants' levels of depression, antidepressant medication use, health risk behaviors (i.e., missing appointments with physicians, forgetting to take medication, not getting enough rest, and not having enough time to exercise), and weight. They found that in general, for non-caregiving older persons, the death of a spouse negatively impacted several indicators of well-being: Levels of depression and the use of antidepressant medications both increased following the spouse's death, and weight loss was also reported among these individuals. There was no change in health risk behaviors for non-caregivers following the spouse's death. The situation was somewhat different for the two groups of caregivers. For non-strained caregivers, only depression increased after care recipient death; use of anti-depressive medication, health risk behaviors, and weight loss did not change. Among caregivers reporting strain, levels of depression, high to begin with, did not change; nor did and anti-depressive medication use or weight loss. However, health risk behaviors actually improved significantly among this subgroup. The death of the spouse apparently allowed the caregiver the freedom to concentrate care on himself/herself. These findings emphasize the strain of caregiving, and emphasize the need for supportive services for recently widowed older persons, regardless of caregiver status.

SECTION II
Research Sponsored by Other NIH Institutes

National Center for Complementary and Alternative Medicine

The mission of the National Center for Complementary and Alternative Medicine (NCCAM) is to support rigorous research on complementary and alternative medicine (CAM), to train researchers in CAM, and to disseminate information to the public and professionals on which CAM modalities work, which do not, and why. To achieve its objectives, NCCAM supports basic and clinical research on CAM, awards grants to train researchers in CAM, and sponsors a variety of outreach activities.

CAM use spans the spectrum of conditions and diseases confronting the American public as a whole, however, it is especially associated with chronic conditions. Consequently, a large component of the NCCAM research portfolio addresses dementia, arthritis, cancer, and cardiovascular disease--conditions affecting the quality of life and longevity of our nation's elderly. Relevant highlights from our 2001 and 2002 research portfolios are described below.

CAM Use by the Elderly. According to the 1999 National Health Interview Survey, approximately 29 percent of all Americans used CAM therapies in the last year. Among the elderly, studies suggest that the percentage of users may be even greater. In 2000, the Journal of Gerontology reported findings from an NCCAM-supported survey of Medicare beneficiaries, which indicated more than 40 percent had used CAM. Of those using CAM, some 80 percent maintained that they experienced substantial benefit from it. The high prevalence of use of dietary supplements combined with inadequate scientific knowledge regarding supplements and the elderly prompted the need for a workshop to be planned by NCCAM and the National Institute on Aging for 2003. Studies indicate that the majority of older people using CAM therapies do not disclose this information to their physicians. These findings underscore the need for conventional physicians to inquire about CAM use by their elderly patients.

Dementia
For centuries, extracts from the leaves of the Ginkgo biloba tree have been used as Chinese herbal medicine to treat a variety of medical conditions. In Europe and Asia, standardized extracts from ginkgo leaves are routinely taken to treat a wide range of neurocognitive symptoms, including those associated with Alzheimer's disease. Little is known, however, about the safe dosage levels of Ginkgo biloba extract, let alone its actual effectiveness in preventing Alzheimer's disease. NCCAM, in collaboration with the National Institute on Aging (NIA), the National Heart, Lung and Blood Institute (NHLBI), and the National Institute of Neurological Disorders and Stroke (NINDS), may help resolve these questions through a six-year, multi-center effort to study the efficacy of Ginkgo biloba extract in preventing dementia, a cognitive decline in memory and other intellectual functions, in older individuals. This study, the largest of its kind ever conducted on Ginkgo biloba, includes four clinical centers and has enrolled over 3,000 research volunteers. Participants who take Ginkgo biloba are being compared to a second group of individuals who are taking a placebo. In addition to this clinical trial, NCCAM is supporting basic research to understand the possible neuroprotective effects of Ginkgo biloba. In 2002,

NCCAM's investment in this area of research yielded a trio of published studies, which concluded that a standardized Ginkgo extract protects cells from oxidative stress and programmed cell death. The Center is also supporting an extensive portfolio of basic research studies using cellular, molecular and animal model systems to explore the possible neuroprotective properties of other botanicals and herbs. For example, extracts of the Hemsley plant (*Cynanchum wildordii*) have been shown to protect cultured nerve cells from harmful substances that accumulate in aging or diseased brains and are being evaluated in ongoing studies.

Osteoarthritis (OA)

NCCAM collaborated with NIAMS to fund the first U.S. multi-center study to investigate the dietary supplements glucosamine and chondroitin sulfate for knee OA. Glucosamine and chondroitin sulfate are two natural substances, found in and around the cells of cartilage, and commonly used today as nutritional supplements. The study is expected to verify their clinical safety and effectiveness alone or in combination in reducing joint pain and improving mobility. The study involves nearly 1,600 OA patients at 13 study centers. NCCAM is also supporting basic studies that are looking at the mechanisms of glucosamine and its pharmacokinetics. Investigators are studying additional CAM interventions, such as acupuncture and herbal therapies, for treating other forms of arthritis and related autoimmune disorders at the Center for Alternative Medicine Research of Arthritis at the University of Maryland, Baltimore.

Cardiovascular Disease

Cardiovascular disease (CVD) accounts for more than 40 percent of all U.S. deaths, and of the Americans who die from CVD, more than 80 percent of them are 65 years or older. To address the public health threat posed by CVD, NCCAM is supporting numerous basic and clinical studies, including the first large-scale clinical trial to determine the safety and efficacy of EDTA chelation therapy in individuals with coronary artery disease (CAD). In 2002, NCCAM, in collaboration with the National Heart, Lung, and Blood Institute (NHLBI), launched the 5-year Trial to Assess Chelation Therapy (TACT) with the goal of enrolling over 2,300 patients at more than 100 research institutions. Additionally, NCCAM supports two major CAM research centers devoted to the study of CVD and related disorders. At the Specialty Research Center for CAM, Minority Aging, and CVD at the Maharishi University of Management in Iowa, researchers, in collaboration with traditionally black universities and medical schools, are testing the efficacy of Vedic medicine, an ancient Hindi system of healing, for reducing mortality and morbidity associated with CVD in high risk, older African-Americans. In 2002, researchers reported that by employing a multi-modality treatment program derived from Vedic Medicine (involving aggressive dietary changes, exercise, anti-oxidant herbal food supplementation, and stress reduction approaches for one year), they were able to significantly reduce the extent of carotid artery wall thickness as an indicator of atherosclerosis in patients at risk for CVD by nearly twenty percent. NCCAM also supports a CAM Research Center for Cardiovascular Diseases at the University of Michigan. Among its activities, the Center is employing a double-blind, placebo-controlled, randomized trial of a standardized extract of the plant Crataegus (Hawthorn) in patients who, despite optimal conventional medical therapy, continue to experience symptomatic heart failure. In addition to these large-scale projects, NCCAM is supporting investigators around the country who are studying the effects of other CAM modalities, such as Qigong therapy and meditation, and herbs, such as garlic, on CVD and other related disorders.

Cancer

According to the Centers for Disease Control and Prevention, one of every four Americans dies of cancer, making it the second leading cause of death. Cancer is a particular concern for older people given the fact that the occurrence of cancer increases as an individual ages; nearly 80 percent of all cancers are diagnosed at ages 55 and older, and 72 percent of all cancer deaths occur in people 65 and older. Vast numbers of cancer patients seek CAM therapies to treat their disease and to alleviate the discomfort of conventional cancer therapy. As evidence, a 2000 survey of cancer patients revealed that nearly 85 percent of them employed at least one CAM therapy while undergoing conventional oncology treatment.

In response to the interest in cancer and CAM, NCCAM has established a robust cancer research program that spans a wide spectrum of research from basic studies to pre-clinical and early phase clinical studies to large-scale clinical trials. NCCAM's activities in FY 2001 and 2002 include the support of two Specialty Research Centers for Cancer, which are conducting basic and clinical studies of several popular CAM therapies. For example, at the Johns Hopkins Center for Cancer Complementary Medicine, researchers are studying the effects of neuroendocrine stress and Chinese herbs on oxidative genome damage as well as assessing a prayer-based intervention in Black women with breast cancer to determine its effects on ameliorating emotional stress associated with diagnosis and treatment and improving immune function. Other activities NCCAM is supporting, in collaboration with the National Cancer Institute (NCI), include a Phase III clinical trial to determine the effectiveness of selenium and vitamin E, either alone or together, in preventing prostate cancer. NCI and NCCAM are also jointly sponsoring a study on the effects of acupuncture on pain, nausea, and quality of life in terminal cancer patients at the Dana Farber Cancer Institute where CAM clinical services have been integrated within the oncology practice. NCCAM and NCI have also negotiated an arrangement that permits NCCAM to solicit and fund competitive, supplemental awards to existing NCI-funded Cancer Centers. The purpose of this awards program is to promote innovative pilot projects in cancer CAM research at these prestigious medical institutions. To enhance scientific knowledge on the role CAM therapies may play in end-of-life care, NCCAM, NCI, and other NIH Institutes and Centers co-funded an initiative to generate research in this area. Finally, NCCAM and NCI collaborated on a series of fact sheets regarding cancer and CAM to ensure the public receives high quality, reliable information.

Menopause

In May 2002, due to an observed increased risk of invasive breast cancer and cardiovascular disease in its participants, NHLBI halted an arm of its Women's Health Study investigating the use of combination estrogen and progestin in postmenopausal women. This action triggered renewed interest in alternatives to hormone replacement therapy. According to the results of SWAN (Study of Women Across the Nation, a 10-year prospective cohort study of women's health co-funded by NCCAM) almost half of all perimenopausal women use some form of CAM. However, sufficient information demonstrating the safety and efficacy of alternative hormone replacement therapies either as treatments for menopausal symptoms, osteoporosis, or heart disease does not exist.

To build a body of scientific evidence, NCCAM funds ongoing research, including a partnership with the NIH Office of Dietary Supplements (ODS) to support the Centers for Dietary Supplement Research. The Centers serve to identify and characterize botanicals, assess bioavailability and activity, explore mechanisms of action, conduct preclinical and clinical evaluations, establish training and career development, and help select the products to be tested in randomized controlled clinical trials. In one of these centers, a multidisciplinary team of investigators studies the clinical safety and efficacy of botanicals for menopause. Additional studies will address identification of active compounds, characterization of metabolism, and pharmocokinetics of active species contained in these botanicals. At other institutions, researchers are assessing whether natural, dietary sources of estrogen prevent postmenopausal bone loss as well as whether treatment with herbs, including black cohosh and red clover, are effective in reducing the frequency and intensity of menopausal symptoms, such as hot flashes.

National Institute of Arthritis and Musculoskeletal and Skin Diseases

Osteoarthritis

Osteoarthritis is the most common form of arthritis in the United States. It is a major contributor to reduced function and loss of independence in the elderly. Also known as degenerative joint disease, osteoarthritis occurs when cartilage begins to fray, wear, and decay causing joint pain, reduced joint motion, and loss of function and disability. As the number of older people in our population continues to grow, osteoarthritis can be expected to affect more of the American public.

The NIAMS partnered with the National Institute on Aging (NIA) to establish a public-private partnership to develop clinical research resources that support discovery and evaluation of biomarkers and surrogate endpoints for osteoarthritis clinical trials. Following several years of effort, the NIAMS and NIA recently joined with other NIH components, including the National Institute of Dental and Craniofacial Research, the National Center for Complementary and Alternative Medicine, the Office of Research on Women's Health, and the National Center on Minority Health and Health Disparities; other Federal agencies; and four pharmaceutical companies in funding the newly launched Osteoarthritis Initiative. For the first time, a public-private partnership will bring together new resources and commitment to help find biological markers for the progression of osteoarthritis. The Osteoarthritis Initiative will fund from four to six clinical research centers to establish and maintain a natural history database for osteoarthritis that will include clinical evaluation data and radiological images, and a biospecimen repository. All data and images collected will be available to researchers worldwide to help quicken the pace of scientific studies and biomarker identification.

The NIAMS is encouraging research studies to evaluate risk factors for the development and progression of osteoarthritis in vulnerable populations such as the elderly.
Several NIAMS funded studies have added significantly to our understanding of the factors that predispose individuals to developing osteoarthritis, particularly of the knee. Factors include obesity, age, injury to joint structures called menisci or cruciate ligaments, repetitive trauma to the joints, congenital malformations, presence of calcium crystals in joints, and undefined genetic factors. It is unclear at what age most patients begin to develop osteoarthritis, since radiologic measurements are relatively insensitive. Cartilage and bone are highly dynamic

structures that demonstrate metabolic and structural changes in osteoarthritis. Recently, researchers undertook a study to determine whether cartilage and bone metabolism was altered in daughters whose mothers had osteoarthritis. The results showed that cartilage degradation was significantly increased in daughters whose mothers had knee osteoarthritis. This finding suggests that predisposition to the development of osteoarthritis begins in the early decades of life. This has important implications for identifying individuals potentially susceptible to osteoarthritis in later life. Further, this study demonstrates the utility of a marker of metabolic processes in cartilage, such as degradation, to assess osteoarthritis risk.

In addition, basic research is focusing on the development of agents that can block the degradation of cartilage cells, caused by various inflammation producing enzymes or cell-death producing enzymes. The identification of these agents as potential cartilage protective agents in cell culture will hopefully lead to their safe and efficacious use in humans. The NIAMS recently created a Cartilage Biology and Orthopaedics Branch and recruited an internationally recognized scientist in cartilage research to head this new Branch. As protocols for tissue regeneration and for skeletal gene therapy and other areas are developed, it is essential that there be an established orthopaedic program and active involvement of orthopaedic surgeons in these protocols, to facilitate tissue harvesting, clinical evaluation of the efficacy of candidate tissue-engineered cartilage products, and most importantly, the translation of laboratory findings to clinical applications. The orthopaedic program will interface with our colleagues in the greater Washington D.C. area.

Osteoporosis

Osteoporosis, once thought to be a natural part of aging among women, is no longer considered age or gender-dependent. It is largely preventable due to the remarkable progress in the scientific understanding of its causes, diagnosis, and treatment. However, osteoporosis continues to be a significant public health challenge for women and men, particularly the elderly.

Reports from the Framingham Osteoporosis Study recently provided important new information on the effect of dietary protein on bone loss in elderly men and women. The role of protein in bone metabolism is an area of some controversy. Dietary protein can cause an increased acid load, which results in the transfer of calcium from bone to maintain acid-base balance. Many laboratory studies have shown that high protein intake is an important and powerful determinant of urinary calcium loss, which can in turn cause negative calcium balance and hence an increase in bone loss. However, other studies have shown that protein under-nutrition is associated with osteoporosis and that low protein intake or even protein "insufficiency" is particularly associated with frailty and fracture in the elderly population. The Framingham Osteoporosis Study recently reported on the relationship between dietary protein intake and the 4-year change in lumbar spine, femoral neck, and radial shaft bone mineral density in this population-based study. Subjects included 391 women and 224 men, and the mean age at baseline was 75 years. Results indicated that lower protein intake was significantly associated with greater bone loss at the spine and femur skeletal sites but not the radial shaft (leg), with subjects having the lowest levels of protein intake showing the highest level of bone loss. Results were consistent after adjustment for important confounding factors, which included body weight loss. The two key findings from this study were, first, that protein intake was found to be important in maintaining skeletal health in the elderly population, and second, a higher intake of animal protein did not appear to have

any detrimental effects on skeletal integrity. This is an important study concerning the role of diet (particularly protein nutrition) on bone health maintenance of the aging population. The results of this study should encourage an adequate consumption of dietary protein in the elderly population and point to the potential benefits of this dietary change on skeletal health.

In addition, basic researchers have reported new insights into the complex effects of estrogen on bone. Bone breakdown, or resorption, is a normal part of bone remodeling, in which old or damaged bone is replaced with new bone. Net loss of bone, leading to osteoporosis, occurs when bone resorption exceeds new bone formation. The most common cause of bone loss is the decline in the female sex hormone, estrogen, in women after menopause. Estrogen also seems to be important for the maintenance of bone mass in men, although men have much less estrogen than the male sex hormone androgen. Yet it remains unclear just how sex hormones influence bone remodeling. It is known that many types of cells have proteins on their surfaces called receptors, which enable the cells to respond to estrogen and the male sex hormone androgen. But it is not clear just which cells are responsible for the effects of estrogen on bone, or even whether estrogen receptors are necessary for estrogen's effects.

Two recent reports from NIAMS-supported researchers have provided important clues to the complex relationship between estrogen and bone, and have demonstrated that there is still much to be learned about the action of estrogen and the function of estrogen receptors. In the most surprising development, investigators have extended earlier work showing that estrogen decreases rates of controlled cell death (called apoptosis) among bone-forming cells (osteoblasts), thus increasing bone formation and preventing net bone loss. Now they find that either estrogen or androgen can have this anti-apoptotic effect, and that it can be mediated by either estrogen receptors or androgen receptors, regardless of which sex hormone is present. It appears that the effects of sex hormones on bone reflect a previously unrecognized function of the estrogen and androgen receptors, which is distinct from their familiar action on reproductive tissues. In a second report, investigators have shown that immune cells called T cells can contribute to the bone loss that occurs when estrogen levels are low through the stimulation of osteoclasts that resorb bone and thereby enhance the susceptibility to fractures.

The use of drugs known as bisphosphonates, which inhibit bone resorption, has brought about a marked improvement in the clinical management of diseases that involve bone loss. However, recent findings suggest that bone loss is associated not only with excessive bone resorption but also with the death of bone-forming osteoblasts. Other bone cells, called osteocytes, which are derived from osteoblasts when the bone-forming cells become embedded in the bone, also die under conditions that lead to bone loss. This may be important because osteocytes seem to be the cells that sense mechanical loading, a requirement for a healthy skeleton. Now, researchers have revealed that bisphosphonates can prevent the death of osteoblasts and osteocytes. It is likely that this action accounts, in part, for the effectiveness of bisphosphonates in treating several different types of bone loss. In addition, if the mechanism by which bisphosphonates prevent cell death can be identified, it may be possible to exploit this effect to a greater degree, leading to therapies that actually increase bone mass.

Although genetic influences are believed to account for up to three-quarters of the variation in bone mass, there is still room for the modifiable factors (including nutrition) to play an important

role. Major attention has been focused on calcium and its importance to bone health, but the roles of other nutritional factors have been under-emphasized. Dietary potassium and magnesium, as well as fruits and vegetables, have been hypothesized to preserve bone mass and prevent bone loss through their effects on reducing the body's metabolic acidity. Investigators have been carefully tracking the association between dietary habits, bone mineral density, and fracture history. Greater potassium, magnesium and fruit and vegetable intake was significantly associated with greater bone mineral density and less bone loss with time. Although there has been a great deal of focus on calcium as a nutrient to preserve bone in the elderly, these research studies confirm that other nutrients and the overall composition of the diet may play a significant, long term role in bone health.

Scientists have also continued to identify, through epidemiologic studies and through imaging studies, factors that can better predict increased fracture susceptibility. Using data from the Study of Osteoporotic Fractures (in which 7782 women were studied), a clinical assessment tool was developed that can be used by women or their physicians to assess the risk of fracture. The variables that were used to develop the tool are: age, fracture after 50 years, maternal hip fracture after age 50, weight of less than 125 pounds, smoking status, use of arms to stand up from a chair, and bone mineral density. This assessment tool now needs to be validated in additional studies. In other studies it was shown that imaging, using an MRI scan of bone, in combination with the bone mineral density determination, can enhance the prediction for fracture risk.

In the area of basic research, NIAMS funded investigators have found that obese mice reveal a new approach to building bone. Investigators studying genetically obese strains of mice made a surprising observation. These mice are defective in the action of a chemical called leptin, which acts through the central nervous system to control food intake along with several other aspects of behavior and physiology. In the absence of leptin's normal action, the mice become very fat. Usually, high body weight results in high bone mass. However, these mice also have defects in the development of the sex organs and have high levels of a naturally occurring chemical called cortisol, conditions that usually cause bone loss. Surprisingly, the mice had very high bone mass. Further, the high bone mass was not due to the obesity, but instead to the absence of leptin function. It seems that leptin normally acts to suppress the bone-forming activity of osteoblasts. Leptin is thought to act mainly through a part of the central nervous system called the hypothalamus. Until these observations, there had been no evidence that the hypothalamus had any effect on bone. Thus, this discovery reveals a previously unknown mechanism by which bone formation is regulated. Leptin, acting through the hypothalamus, may act to inhibit bone formation in some conditions of bone loss. Thus, if drugs can be designed to block leptin's action, they may be useful as therapies to restore lost bone.

The NIAMS, along with the NIH Office of Medical Applications of Research, sponsored a Consensus Development Conference on Osteoporosis Prevention, Diagnosis, and Therapy on March 27-29, 2000. The consensus development panel's statement addressed four key questions: (1) What is osteoporosis and what are its consequences? (2) How do risks vary among different segments of the population? (3) What factors are involved in building and maintaining skeletal health throughout life? (4) What is the optimal evaluation and treatment of osteoporosis and fractures? The panel provided responses to these issues, as well as a number of recommendations for future research across the broad spectrum of studies on osteoporosis. The

major conclusions were that: (1) osteoporosis can be a devastating disorder that often goes unrecognized; (2) risk for low bone density and risks for fractures overlap, but may not be identical; (3) adequate calcium and vitamin D intake and regular exercise as well as gonadal steroids contribute to high peak bone mass; and (4) assessment of bone mass and fracture risk and determination of who should be treated are optimal goals, since effective treatment and prevention

Wound Healing
The NIAMS also invests in research on wound healing. The healing of chronic wounds is a major health problem in the United States. This occurs in both the elderly and in the very young with specific skin diseases. Our understanding of the way the various layers of skin adhere to one another has been a major advance that has come out of basic laboratory investigations of hereditary skin diseases, and it is now being applied to the development of more effective means for treating chronic wounds-whatever the cause. In addition, a major cause of chronic wounds, particularly in the elderly population, is inadequate circulation. However, it is not clear whether oxygen supply at the wound site itself has a positive or negative influence in wound healing.

Low oxygen tension had been shown to stimulate cell growth and to stimulate the synthesis of certain growth factors and components important in wound healing. In a recent study using a tissue culture model to simulate acute wounding and with analysis of oxygen tension (the amount of oxygen available) it was demonstrated that oxygen tension dropped in the areas of model wounds as compared to the unwounded areas of the culture, but interestingly, that the oxygen tension decrease was blocked by inhibitors of cellular protein synthesis. This would indicate that the drop in oxygen tension is the result of increased cellular activity as a wound- healing response, rather than being the cause of the wound. It provides theoretical support for hyperbaric (high pressure) oxygen and other treatments designed to increase oxygen supplied to the tissue from the outside.

National Institute of Dental and Craniofacial Research

Head and Neck Cancers
Squamous cell carcinomas of the head and neck (HNSCC), including those of the oral cavity, represent the 6th most common cancer in the developed world. Head and neck cancers primarily affect the aging population (age 65 and older) and are associated with low survival and high morbidity rates. Surgery, radiation and/or chemotherapy have not improved the 50 percent overall 5-year survival over the past 30 years. Because of their location, the tumors as well as their treatments can lead to long-term functional defects, including inability to swallow, impairment of speech, and even extreme disfigurement, all of which have a significant negative impact on the quality of life. Understanding the complex biological processes in HNSCC will enable scientists to assemble a molecular profile of the genes and proteins that are involved in the development of these tumors. This could, in turn, facilitate the identification of new markers for early detection and novel targets for intervention of these devastating diseases.

The NIDCR supports a broad array of research activities designed to elucidate the molecular mechanisms of HNSCC prevention, development, progression and potential treatment. These

include, but are not limited to, studies on tumor suppressor genes, over-expression of oncogenes, cell cycle progression, cell growth, programmed cell death, as well as molecular mechanisms of aging and senescence in oral epithelial cells. These are all fundamental biological functions that tumor cells manipulate to their advantage in order to survive.

Some of the NIDCR-supported studies are aimed at identifying individuals who may be genetically susceptible to oral cancers due to abnormalities in genes that encode enzymes involved in the metabolism of tobacco carcinogens and alcohol. These studies also are examining race as a possible factor in susceptibility to oral cancers that are associated with specific genotypes for carcinogen-metabolizing enzymes. Some research teams focus on identifying markers for early diagnosis, prognosis and prediction of appropriate therapeutic modalities. Other studies are directed toward the characterization of the mechanisms that underlie the progression of neoplastic cells from a pre-malignant to a malignant state. Additional research efforts focus on the investigation of the mechanisms that control tumor cell invasion and metastasis. Also, in collaboration with the NCI, the NIDCR is co-funding three Specialized Programs of Research Excellence that are conducting extensive translational research on the etiology, screening, diagnosis and treatment of head and neck cancers.

Although studies have established human papillomaviruses (HPVs) as a risk factor for oral and pharyngeal cancer, it is not clear whether viral infection affects survival in head and neck malignancies. However, there is evidence that indicates an interaction between gender and HPV for overall and disease-specific survival suggesting that HPV-infected males have a better prognosis than HPV-negative males. Ongoing studies are investigating the association between positive HPV serology results and various alterations in the molecular pathway of tumorigenesis.

Osteoporosis

Osteoporosis is the leading cause of bone fractures among older Americans. The disease also affects oral bone, which, in turn, can manifest loss of tooth support. In edentulous individuals, osteoporosis may result in extensive alveolar ridge atrophy, thus influencing the outcome of periodontal, pre-prosthetic, and implant surgical procedures.

The NIDCR supports basic and clinical research activities in an effort to understand the pathophysiology of osteoporosis and how best to treat it. Basic research studies are focused on: i) bone remodeling throughout the lifespan; ii) regulated resorption and formation of bone; and iii) the role of osteoclasts (bone destroying cells) and osteoblasts (bone forming cells) in these processes. Investigators funded by NIDCR have defined the genetic mutation in an animal model (tl rat) that results in a severe deficiency of bone-resorbing osteoclasts leading to osteopetrosis, a condition characterized by a sclerotic skeleton, lack of marrow spaces, failure of tooth eruption and other pathologies. Another team of NIDCR-supported investigators has identified connective tissue growth factor (CTGF) as a potent osteogenic agent that is up-regulated during fracture healing and is a potential coupling factor between bone formation and bone resorption. Injections of CTGF into rat long bones induce new bone formation, and blocking CTGF activity in osteoblast cultures inhibits bone nodule formation. Its up-regulation in all osteopetrotic animal models tested, and its decrease during recovery from osteopetrosis, clearly indicates that CTGF promotes bone growth. The studies to date indicate that CTGF may represent a potential therapeutic agent that can be used to increase bone formation or healing, and also, in cases of

extensive bone resorption, such as osteoporosis, blocking of CTGF might reduce osteoclastic bone resorption and prevent further skeletal deterioration. Other scientists supported by the NIDCR are utilizing mesenchymal and subcutaneous fat derived adult stem cells for bone fracture repair in older patients as well as imaging methods for assessment of osteoporotic risk and treatment outcomes.

The benefits of sufficient levels of calcium intake in the prevention of osteoporotic fractures are well recognized. Since alveolar bone is influenced in the same manner as other bones, dietary calcium levels are assumed to also affect its density. It has been suggested that increased alveolar bone density may reduce bone loss during periodontitis (gum disease). Periodontitis is a bacteria-caused chronic inflammatory disease that destroys the bone and tissues that support the teeth. Periodontitis increases in prevalence and severity with aging, and nearly two thirds of elderly adults have severe destructive forms of the disease.

The NIDCR is supporting a study to evaluate the effects of calcium intake on alveolar bone and its capacity to decrease periodontitis-induced bone loss at old age. The researchers are using a rat model, since these animals have previously been used extensively in bone and periodontitis studies and have a relatively short life span, which allows evaluation of the effects of calcium intake at old age, when its benefits are of most value. Sophisticated radiography and other bioimaging techniques are being used to measure the amount and density of alveolar bone and tissue loss. The hypothesis is that increased calcium intake in older animals will reduce the likelihood of the animals losing bone during periodontal infection. Such data could provide an important intervention for reducing the damage caused by periodontal diseases.

In 2001, the NIDCR issued a Program Announcement to encourage research focused on understanding the mechanisms by which fluoride prevents dental caries and osteoporosis, and to improve routines, materials and schemes of fluoride administration. In addition, the NIDCR is one of the NIH Institutes that supports the Osteoporosis and Related Bone Disease National Resource Center, which promotes the dissemination of science-based health information to patients, health care providers, and the general public.

Reducing Tooth Loss and Enhancing Oral Heath in the Elderly

Tooth loss increases as people age, and it has a significant negative effect on the quality of life in the elderly. The NIDCR is supporting research aimed at enhancing oral health in the elderly, and it is supporting a clinical trial to determine if a simple, low-cost intervention is effective in reducing tooth loss in community dwelling elderly adults. Another NIDCR-sponsored study is determining risk factors for tooth loss in adults over 45 years of age. Results indicate that patient preference for dental care, periodontal disease, looseness of teeth, decay, number of fillings, and location of teeth in the mouth are strongly predictive of tooth loss, while other factors such as number of crowns and broken teeth are not predictive of tooth loss. Moreover, poorer general health, being older, and poorer economic status are associated with increased tooth loss.

Relation of Periodontal Disease and Systemic Disease

The prevalence of cardiovascular disease, stroke, diabetes, and periodontal disease increases with age. There are indications that periodontal disease may be an independent risk factor for

cardiovascular disease. Periodontal disease may have a relationship to cardiovascular disease by serving as a reservoir for pathogenic organisms or as an inflammatory lesion that stimulates release of pro-inflammatory cytokines leading to the formation or rupture of vascular plaques and myocardial infarction or stroke. Epidemiological studies are investigating the possible association between periodontal infection and the risk for arteriosclerosis and cardiovascular disease. If such an association is found, clinical trials will be needed to determine if treatment of periodontal disease can reduce the risk for cardiovascular disease and stroke.

People who have diabetes also tend to have more severe periodontal disease, and there are indications that treatment of periodontal disease in people with diabetes may lead to better control of diabetes. Initial studies are being conducted to evaluate the association between control of diabetes and treatment of periodontal disease that may lead to future definitive trials to test if periodontal treatment can aid in the control of diabetes. Additional studies are being conducted to determine the prevalence, incidence and disease progression rates for various oral diseases in people with Type I diabetes.

National Human Genome Research Institute

The recent sequencing of the human genome, led by the National Human Genome Research Institute (NHGRI) at the NIH, along with other achievements in genomics, provides an unparalleled opportunity to advance our understanding of the role of genetic factors in human health and disease, to allow more precise definition of the non-genetic factors involved, and to apply this insight rapidly to the prevention of disease, while anticipating and avoiding potential harm. Therefore, we believe that most of the work funded by the NHGRI, including some in the area of ethical, legal and social implications, will have a profound impact on the study of aging in the years to come. Below are a few specific examples of NHGRI-funded research that are directly tied to aging research.

Alzheimer's Disease

Researchers at the Massachusetts General Hospital and the University of Alabama are studying "Genetic Knowledge and Attitudes in Alzheimer's Disease." This project addresses the ethical, legal, and social implications of the genetic aspects of Alzheimer's disease (AD) from the critical perspective of a group at high risk for the disease: currently unaffected relatives in families with AD. These researchers have been working together since 1990 as part of the NIMH Genetics Initiative to identify families with Alzheimer's disease for genetic linkage study. Nearly 350 such families, predominantly affected sibling pairs and over 300 of their unaffected siblings, have been enrolled. The two centers will use both qualitative and quantitative approaches to study knowledge, attitudes, and behavior related to genetic studies and genetic testing in the unaffected individuals in these AD families and in their primary care physicians, and will develop and pilot educational materials designed to address their needs for genetic information. The genetic educational materials developed and tested in this project strive to meet the current need for accurate information, to prepare physicians and the public for future challenges, and to supply models for genetics education in other complex diseases.

Another study, at Boston University, "Genetic Risk Assessment and Counseling for Alzheimer's Disease," attempts to determine who chooses to obtain susceptibility genotyping for AD and

what the consequences of the information provided by such genotyping would be. Subjects will be randomized to either a control arm, in which risk will be estimated based upon family history or an intervention arm, in which risk will be estimated by family history and by genotyping APOE, a common susceptibility polymorphism. Three clinical centers of care (in Atlanta, New York City, and Cleveland) will enroll adult offspring of persons with AD and, using a carefully monitored protocol of counseling, assess the benefits and risks of providing this information about AD. Determination of APOE status will be used in a format that parallels likely clinical usage and will permit the development of guidelines for clinicians for genetic testing, risk assessment, and counseling.

Parkinson's Disease

For several years, the NHGRI has been actively involved in studying the genetics of Parkinson's disease (PD), a disease that affects the elderly in greater proportion than younger individuals.

In 1997, collaborations with researchers in New Jersey and Italy led to the discovery that mutations in the alpha synuclein gene caused familial PD in a large Italian family. Further studies carried out at the NHGRI revealed that alpha synuclein was a major component of Lewy body plaques seen in the brains of many individuals with PD. Fewer than a half dozen papers had been written on alpha-synuclein before this discovery and now there are well over 500 publications exploring this protein's role in PD.

PET Scanning in Parkinson's Disease

After discovering the importance of this protein in the development of PD, researchers began to examine the function of alpha synuclein. A great deal of effort at the NHGRI has focused on the creation of a genetic mouse model of PD, as this would offer exciting new ways to study PD in terms of both etiology and treatment. In this model, the alpha-synuclein gene is removed and replaced with a mutated form of the human gene. In one case a mouse homozygous for the human mutation appeared to have "Lewy body-like lesions" in a brain region affected by Parkinson's, but there was no clinical phenotype consistent with PD. Research is continuing in this area.

The function of proteins that are important in the development of PD is also being explored in the NHGRI intramural program, through comparisons of normal mice and mice with mutations engineered in genes that may contribute to PD. In addition, studies that evaluate the contribution of protein modifications, protein-protein interactions, and factors that can affect the expression of proteins are also underway.

Since alpha-synuclein has been discovered, two other genes, parkin and DJ1, have been found to be involved in familial PD. Researchers believe that there are many more genes that could cause familial PD; it is thought that at least five other genes will be isolated in the next few years. Therefore, researchers at the NHGRI continue to collect samples from families in which PD seems to be inherited. The hope is that by studying these families, researchers will gain a better understanding of existing genes and possibly discover other genes involved in familial PD. The NHGRI is collaborating with intramural researchers from the NINDS and the NIA to accelerate these discoveries.

Studies on mice deficient in vitamin C transporter
Some of the families enrolled in the gene identification study do not have a sufficient number of clearly affected individuals to perform linkage studies. Therefore, the NHGRI has collaborated with researchers from the NINDS, the NIMH and the NIH Clinical Center to perform PET scans on unaffected and equivocally affected family members, in an effort to ascertain whether they may or may not have inherited the gene. This study will compare the brain's use of dopa in patients with PD, their family members and normal volunteers. Dopa is the precursor of Dopamine and is a chemical normally found in the part of the brain involved in controlling movement. In people with PD the cells that convert dopa to dopamine begin to die and by the time that symptoms of PD begin, they only produce 20-30% of the normal levels of dopamine. The lack of dopamine seems to cause the stiffness and possibly the tremor associated with the condition. It is believed that PET scans may help to classify family members based on the amount of cells they have which can convert dopa to dopamine.

Studies on the role of iron in PD
Multiple studies implicate iron in the pathophysiology of PD as well as other neurodegenerative disorders. Iron levels are elevated in the brains of patients with PD, and the levels of iron-binding proteins are abnormal. In addition to its role in promoting oxidative damage, recent studies suggest that one mechanism by which iron might contribute to PD is by inducing aggregation of the alpha synuclein protein to form Lewy Bodies. Researchers at the NHGRI have found that the addition or omission of iron affects the binding of alpha-synuclein and the data to date suggest a mechanism by which iron may contribute to synuclein aggregation. This work is ongoing.

Genetic enhancement: Enhancement ethics and the molecular genetics of aging
In collaboration with the NIA, the NHGRI's Ethical, Legal and Social Implications program has funded a research project looking at ethical issues related to genetic enhancement. Advances in the molecular genetics of cellular aging raise the prospect of intervening in the human aging process to extend the human life span dramatically. The development of such interventions would confront society with the challenge of interpreting, using, and regulating the ultimate genetic enhancement technology: a technology that could allow us to change a basic constant of human life at the cellular level. This project combines the work of two ongoing research programs. The first is the research that was conducted on the ethical and public policy challenges that are posed generically by genetic enhancement technologies. The framework for ethical analysis and public policy development generated by that research would be applied here to the case of anti-aging interventions, both as a test of the framework and to see what it yields in this case. The second resource is the work on the clinical and social meanings of the human aging process. That research will be used to identify the issues to analyze in this project, by providing the landscape of contemporary social practices, values, and beliefs that radical life extensions could challenge. Collaboratively, the research teams will seek to anticipate the issues that anti-aging interventions could raise for three constituencies: the individuals and families that might use them, the health professionals that might provide them, and the public-policy makers that will shape the context in which they might become available.

The National Library of Medicine

Development of a Senior-Friendly Website. The National Library of Medicine (NLM) remains committed to making health information on the Internet easily available to all citizens – especially older Americans. The NLM's interest in reaching older Americans is two-fold: 1) more and more older people are using the Internet as a source of health information, and 2) Americans over the age of 65 are twice as likely to be hospitalized and incur over 50 percent of health care costs. Clearly, seniors can benefit tremendously from increased access to good, reliable, up-to-date health information from the National Institutes of Health. To better meet the growing information needs of seniors, the NLM and the National Institute on Aging (NIA) have developed NIHSeniorHealth.gov – a new website that is compatible with the cognitive, visual and perceptual changes that occur with age. This new site was beta-tested in 2002. The NLM and the NIA are now working with other NIH Institutes to assist them in the transfer of vital health information into this new senior-friendly format in preparation for a national launch later in 2003.

Health Information Prescriptions. In addition to developing a senior-friendly website, the NLM also remains dedicated to increasing the access seniors have to good health information. Therefore, in the spring of 2002, the NLM partnered with the American College of Physicians and the American Society of Internal Medicine (ACP/ASIM) to launch a pilot project to sensitize patients about the availability of MEDLINEplus – NLM's free, comprehensive, authoritative health information website. Planned to begin in the spring of 2003, ACP/ASIM members in Georgia and Iowa will write "Information Prescriptions (Rxs)" directing their patients to MEDLINEplus as a source of health information on the Internet. Research shows that the public is eager to obtain good sources of health information on the web and are more likely to trust a website that has been recommended by their physician. Based on results of the pilots, the NLM hopes to make Information Rxs available to the public nationwide through their individual health care providers.

Telemedicine and Older Americans. Telemedicine has captured the interest of the medical community, the government, and the public as a cost-effective means of improving access to quality healthcare. In rural areas, where specialized medical care may be unavailable, telemedicine can have an especially large impact on the quality and speed of patient care. But while many people acknowledge the practical advantages of telemedicine, not everyone is at ease with the transmission of confidential patient data over electronic networks. In order to successfully assess and evaluate the results of employing telemedicine, it is necessary that we demonstrate its utility in real-world scenarios. The NLM therefore supported a telemedicine application enabling home care patients to access patient counseling information sources and allow near-time monitoring for patients with chronic ailments. For example, diabetic patients could provide periodic updates of their daily medical logs (blood sugar, weight, medication, well-being) and benefit from early intervention, such as changes in drug dosage, diet, or further check-ups. The NLM found that home care patients with ready access to such information are able to responsibly participate in the healthcare delivery process and its outcome.

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Development of a Senior-Friendly Website. The National Library of Medicine (NLM) remains committed to making health information on the Internet easily available to all citizens – especially older Americans. The NLM's interest in reaching older Americans is two-fold: 1) more and more older people are using the Internet as a source of health information, and 2) Americans over the age of 65 are twice as likely to be hospitalized and incur over 50 percent of health care costs. Clearly, seniors can benefit tremendously from increased access to good, reliable, up-to-date health information from the National Institutes of Health. To better meet the growing information needs of seniors, the NLM and the National Institute on Aging (NIA) have developed NIHSeniorHealth.gov – a new website that is compatible with the cognitive, visual and perceptual changes that occur with age. This new site was beta-tested in 2002. The NLM and the NIA are now working with other NIH Institutes to assist them in the transfer of vital health information into this new senior-friendly format in preparation for a national launch later in 2003.

Health Information Prescriptions. In addition to developing a senior-friendly website, the NLM also remains dedicated to increasing the access seniors have to good health information. Therefore, in the spring of 2002, the NLM partnered with the American College of Physicians and the American Society of Internal Medicine (ACP/ASIM) to launch a pilot project to sensitize patients about the availability of MEDLINEplus – NLM's free, comprehensive, authoritative health information website. Planned to begin in the spring of 2003, ACP/ASIM members in Georgia and Iowa will write "Information Prescriptions (Rxs)" directing their patients to MEDLINEplus as a source of health information on the Internet. Research shows that the public is eager to obtain good sources of health information on the web and are more likely to trust a website that has been recommended by their physician. Based on results of the pilots, the NLM hopes to make Information Rxs available to the public nationwide through their individual health care providers.

Telemedicine and Older Americans. Telemedicine has captured the interest of the medical community, the government, and the public as a cost-effective means of improving access to quality healthcare. In rural areas, where specialized medical care may be unavailable, telemedicine can have an especially large impact on the quality and speed of patient care. But while many people acknowledge the practical advantages of telemedicine, not everyone is at ease with the transmission of confidential patient data over electronic networks. In order to successfully assess and evaluate the results of employing telemedicine, it is necessary that we demonstrate its utility in real-world scenarios. The NLM therefore supported a telemedicine application enabling home care patients to access patient counseling information sources and allow near-time monitoring for patients with chronic ailments. For example, diabetic patients could provide periodic updates of their daily medical logs (blood sugar, weight, medication, well-being) and benefit from early intervention, such as changes in drug dosage, diet, or further check-ups. The NLM found that home care patients with ready access to such information are able to responsibly participate in the healthcare delivery process and its outcome.

percent vs. 19 percent. Thus ST-segment monitoring may be desirable in the telemetry unit as well in order to detect TMI, since these patients may need more aggressive therapies.

Relationship of Decline of Function and Treatment of Cancer Patients
Cancer treatment can affect the physical functioning of elderly patients. In analyzing these effects in order to develop interventions, nurse researchers surveyed 826 patients over 65 years of age, who were recently diagnosed with breast, colon, prostate and lung cancer. The subjects were interviewed within 8 weeks of their diagnosis and asked to rate their level of functioning prior to diagnosis and at the current time. They were also asked about comorbid conditions; symptoms of pain, fatigue, and insomnia; and treatment. Prior to diagnosis, patients reported relatively high functioning that was comparable to the general population, with no correlation to the site and stage of the undetected cancer. After diagnosis, fifteen percent of patients with breast cancer, twenty-three percent with colon or lung cancer, and six percent with prostate cancer had a moderate decline in function, and about one-fourth of all patients showed a steep decline, with treatment playing a role. For example, prostate cancer patients with no treatment or with radiation had better function than those who underwent surgery and showed the greatest decline. Comorbidities did not contribute to loss of function, and pain, fatigue and insomnia had separate negative effects. These findings suggest that management of symptoms early in treatment for cancer may be a key to helping elderly cancer patients better retain their functioning.

Behavioral Intervention for Urinary Incontinence
Research has shown that rural older women with the common condition of urinary incontinence (UI), who received a behavioral management intervention in their homes, reduced UI severity by a surprising 61 percent, compared to the control group, whose UI severity increased by 184 percent. These older women were particularly vulnerable, because they are often poor, and healthcare resources and long-term care facilities are lacking in rural areas. The findings were based on data collected two years after the women began the study. The intervention consisted of three phases – bladder training, self-monitoring of liquid intake and output, and pelvic muscle (kegel) exercises with biofeedback. The three-phase behavioral intervention has been incorporated into the best practice guidelines of the Association of Women's Health, Obstetric and Neonatal Nurses, the professional organization that specializes in improving the health care of women and children of all ages.

Gender Differences in Symptoms of Irritable Bowel Syndrome
In a study of irritable bowel syndrome (IBS), gender plays a prominent role as it does in other disorders. Researchers studied over 700 elderly patients with IBS patients and found that although both genders reported similar levels of GI symptom severity, psychological symptoms, and the impact of the illness on their lives, female patients more often reported such symptoms as nausea, morning muscle stiffness, side effects from medications, and food and taste changes. Thus for older women, IBS may also represent altered sensory processes, autonomic responses, and/or a higher level of vigilance about symptoms.

Institutional and Family Caregiving

Telephone Intervention for Caregivers of Stroke Patients
Caregivers of stroke patients who have been discharged from a rehabilitative facility need support with social problem-solving to avoid burnout and depression. Researchers tested the effectiveness of a telephone intervention, which consisted of an initial three-hour home visit by a nurse, followed by three months of weekly and bi-weekly phone contacts. Findings indicated that compared to controls, the intervention group had better problem-solving skills, less depression, better social functioning and mental health, and better caregiving skills. Telephone interventions with this population appear to be an effective approach to assist them in caring for their relatives while maintaining their own health.

Descriptive Study of Factors in Family Caregiving of AD Patients
Investigators conducted a study to discover what it is really like to care for an AD patient in the home. They interviewed 103 caregivers and found that they spend an average of 117 hours a week, or more than 16 hours a day, in direct caregiving, while receiving less than 5 hours of professional help a week. Not surprisingly, they most frequently mentioned stress and frustration, along with the heartbreak of watching their relatives' slow deterioration. Yet 78 percent of these caregivers spoke of positive aspects. They were willing to sacrifice a great deal to keep the patient in the home. The most successful caregivers were those who managed to integrate caregiving into their lives, have family and community support, and find meaning and joy in care. This information will help guide future interventions to provide assistance to family caregivers of AD patients.

The Caregiving Experience of Female Asian Immigrants
Another study that describes the caregiving experience involved Asian women, particularly immigrants, who must cope with caregiving demands and employment demands, while trying to adapt to U.S. cultural differences. Of particular difficulty for them were emphases on the independence of women and rights of the individual, which contrast with Asian cultural norms. Researchers studied Chinese and Filipino women who had been caring for elderly parents for at least 11 years. Findings indicated that while both groups experienced caregiver stress, they also had high role satisfaction. Investigators concluded that interventions that emphasize the positive side of caregiving and stress reduction are more effective than those that decrease the extent of involvement in family caregiving.

A Workshop for Family Caregivers of AD Patients
Researchers studied a population of 94 family caregivers of AD patients to assess a weekly two-hour training workshop. The workshop provided information on dementing diseases, practical skills for dealing with AD, and ways to improve confidence, coping and communication. The AD patients simultaneously attended daycare activities and received a cognitive functioning assessment. Offered over a seven-week period, the workshop results indicated caregivers' negative reactions to patients' disruptive behaviors and their perceptions of caregiver burden were reduced, and those who were depressed at the time of training were less depressed after completion of the program.

End of Life and Palliative Care

The Role of Advance Directives in Reducing Stress of Family Members of Hospitalized Patients at the End of Life

The majority of deaths in the U.S. still occur within the hospital setting, and almost 70 percent of hospital deaths follow a decision to limit aggressive treatment. Usually the patient is incapacitated, and the decision to withdraw life support rests with family members. In exploring factors contributing to stress among these family members, researchers reported that their stress levels were extremely high, even after six months, when they had to decide whether or not life support should be withdrawn from relatives too incapacitated to decide for themselves. Stress levels were twice as high as those due to other serious crises, such as losing a home to fire. Stress was least severe when patients' written advance directives were available and most severe in the absence of written or verbal directives. Researchers also studied how families made decisions. In the absence of advance directives, families were more likely to push for prolonging life even when treatments were not working and the patient was suffering. When the patient had a written advance directive to guide the family, the family was more comfortable focusing on the patient's quality of life as a guide to reaching the decision to stop life-sustaining treatments.

National Institute of Mental Health

Fostering an understanding of healthy aging and mental health is essential to better care and better living for older Americans. All too often, for example, older individuals and their doctors accept depression as a normal part of aging when it is not. [1] This belief is especially unfortunate for those who first develop depression late in life, when such resignation can prevent the individual from receiving effective care.[2] Untreated depression, after all, is a deadly disease, and the impact is seen in the fact that older Americans are disproportionately likely to die by suicide. Representing only 13 percent of the U.S. population, individuals age 65 and older accounted for 18 percent of all suicide deaths in 2000.[3] Of the nearly 35 million Americans age 65 years and older, an estimated 2 million have a depressive illness and another 5 million may have depressive symptoms that fall short of meeting full diagnostic criteria for a disorder.[4] In short, depression among older Americans should be screened for and treated no differently than other illnesses that become prevalent later in life, such as diabetes or high-blood pressure.

The National Institute of Mental Health (NIMH) program of research on aging includes studies in the basic sciences as well as research in neurobiology and brain imaging, clinical neuroscience, treatment assessment, psychosocial and family studies, and service systems research. Studies involve mental disorders with initial occurrence in late life as well as illnesses

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[1] Lebowitz B.D., Pearson J.L., Schneider L.S., Reynolds C.F. III, Alexopoulos G.S., Bruce M.L., Conwell Y., Katz I.R., Meyers B.S., Morrison M.F., Mossey J., Niederehe G., and Parmelee P. Diagnosis and Treatment of Depression in Late Life. Consensus Statement Update. *Journal of the American Medical Association*, 278(14):1186-1190, 1997.

[2] Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Mental Health. *Older Adults: Depression and Suicide Facts*. NIH Publication No. 03-4593, revised May 2003, available at http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm#8.

[3] Office of Statistics and Programming, NCIPC, CDC. Web-based Injury Statistics Query and Reporting System (WISQARS™), available at http://www.cdc.gov/ncipc/wisqars/default.htm.

[4] Conwell Y. "Suicide in Later Life: A Review and Recommendations for Prevention." *Suicide and Life Threatening Behavior*, 31(Suppl): 32-47, 2001.

that begin in early adulthood but continue throughout the life course. Major areas of research focus are the psychiatric aspects of Alzheimer's disease and related dementias, depressive disorders, schizophrenia, anxiety disorders, and sleep disorders.

One of the goals of NIMH's aging research portfolio is to fund research that addresses the barriers that prevent older Americans from receiving effective treatment for depression and other mental illnesses. Another is to develop a greater understanding of the basic processes underlying these illnesses and to develop more effective treatment and preventive interventions. Effective treatment of mental disorders, while beneficial in its own right, also can lower the burden and costs of other medical conditions, such as cardiovascular disease and diabetes, which occur frequently in aging populations. Studies of health care systems indicate that the presence of depression raises the costs of overall yearly health care by 50 percent or more, and that the magnitude of the added expense grows in proportion to the number of chronic medical conditions that are present.[5]

Given the increasing urgency to address the mental health needs of older citizens, NIMH has undertaken several efforts to advance mental health research in this area. First, a consortium, the NIMH Aging Research Consortium, was established in January 2002 to: stimulate research on mental health and mental illness to benefit older adults; maintain an infrastructure to better coordinate aging research throughout the Institute, both extramural and intramural; provide a linkage to the Institute for researchers, advocates, and the public; and to advance research training for the study of late life mental disorders.

The Consortium sponsored several workshops. "Proxy and Surrogate Consent in Geriatric Neuropsychiatric Research: Informing the Debate," July 1, 2002, was a discussion about the use of legally authorized representatives to provide consent for individuals who lack the capacity to do so. This issue is common for disorders of late-life, including Alzheimer's disease and psychotic depression. Participants included researchers, ethicists, legal scholars, chairs from Institutional Review Boards, members from the Office of Human Research Protection at the Department of Health and Human Services, and representatives from advocacy organizations. Another workshop, "Advancing Mood Disturbance Research in Late Life," July 10-11, 2002, convened epidemiologists, clinical trial investigators, as well as basic and services researchers to discuss mood symptomatology in late-life for those individuals who fail to meet formal diagnostic criteria for a mood or anxiety disorder.

In 2003, Dr. Thomas Insel, Director, NIMH, and the National Advisory Mental Health Council (NAMHC) convened a subgroup, the Aging Research Workgroup, to assess the Institute's extramural aging research and training portfolio. Expertise of the members of the subgroup included minority health, social and behavioral science, HIV/AIDS, genetics, epidemiology, public health, health care management, health policy, and geriatric mental health. The report of the workgroup and its recommendations is available at http://www.nimh.nih.gov.

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[5] Unutzer, J., Patrick, D.L., Simon, G., Grembowski, D., Walker, E., Rutter, C., and Katon, W. "Depressive Symptoms and the Cost of Health Services in HMO Patients Aged 65 years and Older. A 4-year Prospective Study." *Journal of the American Medical Association*, 277(20):1618-1623, 1997.

In August 2002, NIMH released a Program Announcement (PA), Informal Caregiving Research For Chronic Conditions (PA NUMBER: PA-02-155) with the National Institute of Nursing Research (NINR) and the National Institute of Child Health and Human Development (NICHD) to invite applications for research grants to advance the science in informal caregiving by focusing on the caregivers of individuals with chronic illness, disability, or functional impairment requiring partial or full dependency on others. Previous research has shown that caregiving is a significant risk factor for illnesses such as depression in the caregivers. This PA targets studies of informal caregiving to improve caregiver health and quality of life, caregiving processes, and caregiving effectiveness and health outcomes. The Centers for Disease Control and Prevention reports that nearly three quarters of adults age 65 years and older have one or more chronic illnesses, and nearly half report two or more. In a study of caregiving the main illness or problems experienced by care recipients in the study were "aging" (15.5%), mobility problems (10.4%), dementia (9.7%), and 43.2% with various chronic diseases including heart disease, cancer, stroke, arthritis, diabetes, and pulmonary disease. [6]

In October 2002, NIMH released PA 03-014, Research on Mental Illnesses in Older Adults. This PA is designed to intensify investigator-initiated research in this area, to attract new investigators to the field, and to enhance interdisciplinary approaches to research. Virtually every area of mental health research in aging populations is encouraged.

In the area of HIV/AIDS research, effective strategies for AIDS prevention and treatment through behavior change interventions for the major populations at risk have been identified but not yet applied to the fifty plus population. NIMH supported an NIA request for applications, RFA-AG-01-004, "Planning Grants For HIV/Aids Prevention and Treatment Intervention in Middle-Aged and Older Populations" (January 8, 2001). NIA and NIMH invited qualified researchers to submit applications for planning grants (R21) to assist in the design, testing and preliminary evaluation of prevention and treatment interventions for HIV/AIDS in the middle-aged and older population.

EXAMPLES OF RESEARCH FINDINGS:

Depression and mild cognitive impairment in late life.
The relationship between depression and dementia represents a continuing problem for diagnosis and treatment. Older depressed individuals with mild cognitive impairment, but not dementia, received antidepressant medication and/or electroconvulsive (ECT) treatment and were followed to see whether their cognitive deficits improved with treatment for their depression. ECT has been found to be particularly effective for treatment of depression in older adults. Depressive symptoms were found to improve over a 12-month period, with most of the improvement occurring between the initial assessment and one occurring six months later. Cognitive status (as measured by the Mini-Mental State Exam) followed a similar pattern, with most of the improvement occurring in the first six months of treatment; however, gains were palpably less pronounced than for depressive symptoms. Greater initial severity of depression was associated with significantly smaller improvements in cognitive functioning. The results indicate that

[6] National Alliance for Caregiving & American Association of Retired Persons (1997). Family caregiving in the U.S.: Findings from a national survey. Sponsored by the National Alliance for Caregiving, Bethesda MD, and the American Association of Retired Persons, Washington DC.

cognitive functioning can be improved to some extent by treatment for depression, but that other factors may contribute to continuing cognitive impairment. [7]

Depression after coronary surgery elevates the risk of adverse cardiac outcomes.
Depression has frequently been implicated with an adverse course in cardiovascular disease. This study evaluated depressive symptoms at 6 months after elective coronary artery bypass graft surgery, as they predicted the subsequent course of cardiac morbidity and mortality at up to three years following surgery. Patients were in the age range of 65 to 75 years old. Patients who had low scores for depressive symptomatology before their operation, and who completed a follow-up at 6 months, were contacted again 36 months after surgery to assess cardiac and neurologic morbidity and mortality. The rate of combined new cardiac morbidity/mortality between 6 and 36 months was 13.6% among those who showed newly increased depressive symptoms at 6 months, versus 3.0% in the patients without new depressive symptoms at 6 months. Only an increase in depressive symptoms at 6 months was related to the occurrence of subsequent cardiac complications between 6 and 36 months. In this small sample, depression resulted in a four-fold increase in cardiac morbidity or mortality, illustrating the need for adequate treatment of depression in these older adults.[8]

Treatment of late-life depression in the very old.
While much aging research has found it useful to classify individuals in terms of their relative age, this variable has been examined less often in late-life depression. In this study, the authors examined the relationship of age to treatment response, course of illness, and success rates. By combining three studies of elderly depressed patients, data were available on 323 patients, treated with the anti-depressants nortriptyline or paroxetine. The patients were grouped in three groups of 'young-old' (59-69), 'middle-old' (70-75), and 'older-old' (76-99). Statistical analyses were conducted on scores for a common scale of depression severity, the Hamilton Rating Scales for Depression, over 12 weeks of acute treatment. The older patients responded just as quickly and successfully as the young- and middle-old. These results are very important in showing that at any age, adequate treatment for depression can result in successful outcomes.[9]

Services research studies nursing homes and mental health.
Two studies by Castle investigated aspects of care for elderly people in nursing home settings. The first examined characteristics of nursing homes that were cited as having mental health care deficiencies by the Centers for Medicare and Medicaid Services in 1998. Findings suggest that structural rather than process factors have a significant influence on the number of such care efficiencies cited at a given facility. Particular structural factors -- staffing, private-pay occupancy, and Medicare occupancy -- appear to have the most important influence on the number of mental health citations. Most importantly, these findings suggest that organizational level interventions may have the most impact on improving mental health care in nursing

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[7] Taylor WD, Wagner HR, and Steffens DC: Greater depression severity associated with less improvement in depression-associated cognitive deficits in older subjects. American Journal of Geriatric Psychiatry 10:5: 632-635, 2002.

[8] Peterson, Janey C; Charlson, Mary E; Williams-Russo, Pamela; Krieger, Karl H; Pirraglia, Paul A; Meyers, Barnett S; Alexopoulos, George S. New postoperative depressive symptoms and long-term cardiac outcomes after coronary artery bypass surgery. American Journal of Geriatric Psychiatry. Vol 10(2) Mar-Apr 2002, 192-198.

[9] Gildengers, Ariel G; Houck, Patricia R; Mulsant, Benoit H; Pollock, Bruce G; Mazumdar, Sati; Miller, Mark D; Dew, Mary Amanda; Frank, Ellen; Kupfer, David J; Reynolds, Charles F. III. Course and rate of antidepressant response in the very old. Journal of Affective Disorders. Vol 69(1-3) May 2002, 177-184.

facilities.[10] The second was a meta-analysis of 78 studies that assessed the potential negative and positive outcomes of relocation of the elderly. Outcomes included psychological or social changes, as well as changes in mortality and morbidity. Factors that appear to be associated with positive outcomes in these areas were identified, laying the groundwork for development of preventive interventions for elderly going through relocation.[11]

Effects of cerebrovascular risk factors on outcome of treatment for late-life depression.
Informal clinical observation has led to the impression that late-life depression associated with cerebrovascular disease is relatively resistant to treatment, and has more persisting functional impairment. The current study specifically tested the relationship of cerebrovascular risk factors to clinical presentation and treatment outcome in patients with a mean age of 67.4 years who were enrolled in a long-term maintenance treatment study for depression. Risk factor scores were generated with a scale known as the Probability of Stroke Risk Profile. In the High-Risk group, a greater proportion of patients had their first-onset depression after age 60 as compared to the other group. However, neither high risk scores nor late onset of depression had any effect on the time to remission of symptoms, the need for adjunctive medication, or increased risk for recurrence during a three-year follow-up period. These results suggest that successful treatment for late-life depression treatment is not necessarily impeded by the presence of high cerebrovascular risk, and suggest the need to provide adequate treatment for such patients.[12]

Duration of depressive illness has cumulative effects on the brain.
Modern brain imaging techniques now permit the study of structural brain changes that may be associated with mental disorders. A recent study compared the volumes of various brain regions in depressed elderly patients with those of nondepressed elderly persons, using a structural magnetic resonance imaging technique. The results showed that patients with depression had smaller right hippocampal volume than the control group. Further, a greater number of years since the first lifetime episode of depression was strongly related to a progressively smaller volume of the hippocampal cortex. These data provide evidence of structural brain abnormalities in geriatric depression, and suggest that a longer course of illness is associated with cumulatively larger changes.[13]

White-matter lesions affect the course of late-life depression.
This study tested the hypothesis that microstructural abnormalities in white matter areas of the brain connecting the frontal lobes with the motivational systems of the brain are associated with a low rate of remission of geriatric depression. Thirteen older patients with major depression received treatment with an antidepressant of the selective Serotonin reuptake inhibitor-type for 12 weeks. A form of magnetic resonance imaging, which can image white matter tracts in the brain, known as diffusion tensor imaging, was used to examine preselected white matter regions. Analyses revealed that lesions in the left frontal white matter regions were associated with a low

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[10] Castle NG. Deficiency citations for mental health care in nursing homes, Adm Policy Ment Health. 2001 Nov;29(2):157-71

[11] Castle NG., Relocation of the elderly, Med Care Res Rev. 2001 Sep;58(3):291-333

[12] Miller, Mark D; Lenze, Eric J; Dew, Mary Amanda; Whyte, Ellen; Weber, Elizabeth; Begley, Amy E; Reynolds, Charles F. 33. Effect of cerebrovascular risk factors on depression treatment outcome in later life. American Journal of Geriatric Psychiatry. Vol 10(5) Sep-Oct 2002, 592-598.

[13] Bell-McGinty, Sandra; Butters, Meryl A; Meltzer, Carolyn Cidis; Greer, Phil J; Reynolds, Charles F. 33; Becker, James T. Brain morphometric abnormalities in geriatric depression: Long-term neurobiological effects of illness duration. American Journal of Psychiatry. Vol 159(8) Aug 2002, 1424-1427.

remission rate after age was considered. Remission was not significantly associated with lesions in the lower frontal regions or a temporal region. This study shows that microstructural white matter abnormalities in a particular area of the brain lateral to the anterior cingulate gyrus may be associated with a low rate of remission of geriatric depression.[14]

Office of Research on Women's Health

The Office of Research on Women's Health (ORWH) implements its research objectives by funding and co-funding research in collaboration with NIH institutes and centers, sponsoring research planning conferences on women's health, and recommending or developing new research initiatives. Current research on women's health contributing to developments in aging that is being funded by ORWH includes interdisciplinary approaches to chronic multi-systemic diseases with multi-factorial etiology, healthy living and the impact of diet, physical fitness, obesity, tobacco and alcohol use, the menopausal transition and the mechanisms and prevention of chronic diseases such as diabetes, osteoarthritis, osteoporosis, breast cancer, cardiovascular disease, urinary incontinence and others. During 2001 and 2002, the Office of Research on Women's Health (ORWH) supported a number of research activities with NIH institutes and centers that specifically address the health of older Americans, including:

A Fall Prevention Program for High Risk Elderly Women (NINR)
The long term objective of this study is to develop cost-effective, community-based strategies for the prevention of falls in high risk elderly women. This research will: 1) Test the efficacy of a fall prevention program for high risk elderly women on fall rates over one and two years; 2) Determine the effects of the fall prevention program on postural competence, functional performance, and a variety of other outcome measures; and 3) Identify demographic, clinical, personal, functional, and postural competence variables that predict long-term exercise adherence for participants in the fall prevention program. This study will provide information on the efficacy and cost of simple interventions designed to prevent falls and fall-related injuries, reduce preclinical disability, maintain long-term exercise adherence, and improve quality of life for older women.

Age Difference of Spouses and Long-Term Care (NIA)
The magnitude of long-term care expenditures, $100 billion annually, makes it imperative for us to understand past and future trends in long-term care demand. The aim of the proposed research is to examine how the declining age gap between spouses will affect future trends in the demand for long-term care. It has been well-established that the presence or absence of a healthy spouse is a major determinant of nursing home entrance: a disabled person married to a healthy spouse is about half as likely to enter a nursing home as a disabled person without a healthy spouse. Data from the Asset and Health Dynamics Among the Oldest Old (AHEAD) study will be used to estimate the probability of nursing home entrance by disability, marital status, and the age of a married person's spouse. As part of this analysis, Census data will be utilized to impute data on

[14] Alexopoulos, George S; Kiosses, Dimitris N; Choi, Steven J; Murphy, Christopher F; Lim, Kelvin O. Frontal white matter microstructure and treatment response of late-life depression: A preliminary study. American Journal of Psychiatry. Vol 159(11) Nov 2002, 1929-1932.

the ages of deceased spouses absent from the AHEAD. This analysis quantifies the effect of the changing age gap of the probability of nursing home entrance for married people. Using estimates of the changing probability of being married, and the changing probability of nursing home entrance for married people, the total effect of the changing age gap on overall nursing home demand will be computed.

Aging of Brain: Effects of Prenatal Nutrition (NIA)
The goal of this study is to determine the mechanisms by which the availability of choline and folic acid during the prenatal period modifies brain structure and function in development, adulthood and old age. The proposed studies will 1) determine the molecular mechanisms involved in the brain reorganization that is governed by choline and folate availability by studying signal transduction pathways and developmental patterns of gene expression in brain; 2) measure synaptic function and plasticity in the hippocampus of rats exposed to varying levels of choline or folate in utero; 3) examine age-related changes in conditioned stimulus processing (attention) as a function of the prenatal availability of choline and folate; 4) determine if supplementation with folate in early development leads to lifelong changes in spatial memory, brain anatomy and neurochemistry; 5) investigate whether choline supplementation either prenatally or across the lifespan ameliorates behavioral, anatomical, and biochemical deficits seen in mice lacking the apolipoprotiein E.

Black Rural and Urban Caregivers Mental Health Functioning (NIA)
This study will assess the mental health and social functioning of rural and urban African-American women who provide unpaid care to an elder (65 years and older) by using a cross-sectional research design and random sample of elders. This study will identify the type and quality of caregivers' formal and informal service use. Data will be obtained through personal interviews.

CVD Risk and Health in Postmenopausal Phytoestrogen Users (NHLBI)
In the United States, heart disease is the leading cause of death in postmenopausal women. Estrogen replacement therapy is beneficial for heart disease risk factors as well as for bone density. However, a large proportion of postmenopausal women are not compliant with therapeutic regimens. Phytoestrogens are naturally occurring compounds found in plants and soy products that have estrogenic effects, and may represent an alternative treatment for the prevention of heart disease and osteoporosis in postmenopausal women. However, few intervention trials have examined the extent to which it is possible to improve heart disease risk factors, bone density, and quality of life in postmenopausal women through use of a dietary supplement of Phytoestrogen. The proposed randomized, double-blind, placebo controlled study is designed to determine the acceptability and benefits of use of a dietary supplement of Phytoestrogen (genistein) versus placebo on heart disease risk factors, bone density and psychosocial outcomes in postmenopausal women aged 45-74. Given that women can expect to live one-third of their lives after menopause, the investigators point out that it is important to know how Phytoestrogen may modify heart disease risk factors and bone density. They further state that by defining the influence Phytoestrogen use has, this study would contribute to the understanding of how to prevent cardiovascular disease and osteoporosis in postmenopausal women and thereby improve their quality of life.

Diabetes Prevention Program (DPP) (NIDDK)
By selecting populations at higher than average risk for the ultimate development of non-insulin-dependent diabetes mellitus (NIDDM), the Diabetes Center at the Albert Einstein College of Medicine will test the following hypothesis: The reduction in risk of developing NIDDM in persons at high risk for the development of diabetes will be dependent on treatment which affects insulin resistance, islet B-cell dysfunction, and/or hepatic glucose production. Interventions which include diet, exercise, sulfonylurea drugs, and metformin in a factorial design can address this hypothesis. The Albert Einstein Center has a large, identified population of individuals from racial and ethnic minority groups in the Bronx and Westchester Counties who receive their medical care in Einstein-affiliated programs; an identified and well characterized population of women who had gestational diabetes diagnosed between 1988 and the present, and an annual accrual of an additional cohort of women with gestational diabetes; members of the treatment team with specific competence in diabetes in Hispanic and in African-American individuals; expertise in related areas such as hypertension control, cardiovascular risk reduction, and behavioral techniques intended to achieve therapeutic goals.

Diabetes Prevention Program (DPP) Primary Prevention Trial (NIDDK)
The primary goal of the proposed project is to determine, via a collaborative multicenter trial, whether interventions can: a) prevent persons with impaired glucose tolerance (IGT) or a history of gestational diabetes mellitus (GDM) from developing non-insulin-dependent diabetes mellitus (NIDDM); and b) prevent the worsening of glucose tolerance in people with newly diagnosed NIDDM. Because of the ethnic diversity of the study populations, a secondary goal is to design the interventions to be sensitive to varying social, ethnic, and cultural values. Using a randomized control group comparison design, the relative effectiveness of the proposed interventions in reducing conversion to NIDDM in persons with IGT, and deterioration of glucose tolerance in newly diagnosed NIDDMs as primary end points and macrovascular risk factors, coronary events, and overall mortality as secondary end points will be evaluated.

Diabetes Prevention Program (DPP) (NIDDK)
This is a multi-center trial in which subjects would be screened for inclusion and exclusion criteria. A primary prevention subgroup will consist of subjects with impaired glucose tolerance (IGT) by National Diabetes Data Group (NDDG) criteria with a fasting plasma glucose (FPG) equal to or more than 110 mg/dl. A secondary intervention subgroup will consist of individuals with NIDDM by NDDG criteria and a FPG < 140 mg/dl. The subjects will be randomized in a 2 x 2 factorial design to: 1) intensive program of diet, exercise and stress reduction versus standard dietary and exercise advice as well as 2) therapy with either glipizide or placebo. The diet/exercise intervention will be modeled after the PATHWAYS program (diet, exercise and stress management) which has been validated as an effective method of weight reduction in inner city African-American women. Individuals will be followed to test whether these interventions can: 1) prevent the worsening of glucose tolerance in these subjects over 5 years and 2) reduce cardiovascular morbidity and mortality.

Doxycycline Effect on Osteoarthritis Progression (NIAMS)
Osteoarthritis (OA) of the knee is the most common cause of chronic disability in this country. Prophylactic oral administration of doxycycline (doxy) markedly reduces the severity of

cartilage damage in a canine model of OA. Even when therapy was initiated after cartilage lesions were established, a protective effect was apparent. Similar results have been noted in guinea pig and rabbit models of OA. The effect is associated with reduction in the levels of collagenase and gelatinase in the OA cartilage. Based on the encouraging data in animal models of OA, a randomized-placebo-controlled 30-month clinical trial will examine the effect of this drug and its ability to prevent the progression of early knee osteoarthritis in women.

Evidence Report - Gender Differences in Cardiac Care (AHRQ)
This Phase II project builds upon the findings and recommendations from the initial study that identified the scientific evidence and basis relating to sex and gender differences in coronary heart disease, its diagnosis and subsequent treatment. The recommendations will be considered by the Evidence Practice Centers and AHRQ. A comprehensive evidence report on the prioritized set of questions that focus on the gender-based difference in diagnosis and treatment related to coronary heart disease, both in-hospital and chronic, will be developed. The study population is adult females, including major racial/ethnic minorities and the elderly.

Hormonal Regulation of Angiotensin Receptors (NIA)
The sexual dimorphism associated with many cardiovascular and renal diseases related to aging is well documented with the risks being significantly higher for men than women. Two of the major risk factors in these diseases are felt to be increased activity of the renin angiotensin system (RAS) and estrogen deficiency. Furthermore, there is accumulating evidence that estrogen may have a regulatory influence on the RAS. In view of its considerable potential physiologic and pathophysiologic significance, this study will investigate how estrogen regulates the activity of the RAS. Specific hypotheses to be tested in the proposed studies are: 1) estrogen down-regulates the density of the type 1 angiotensin receptor subtype (AT_1) expressed in adrenal and kidney tissues and thereby attenates tissue responsiveness to the hormone, angiotensin II (Ang II); 2) estrogen mediates its effects on AT_1 receptor AT_1 receptor expression in these tissues via the estrogen type β ($_{Er\beta}$) receptor; 3) estrogen has direct effects on AT_1 receptor expression by modulating receptor transcriptional and/or posttranscriptional mechanisms; 4) estrogen also acts to decrease AT_1 receptor expression by modulating the local production of Ang II; and 5) the ability of estrogen to down-regulate Ang II activity in the adrenal and kidney is attenuated in animal models of salt-sensitive hypertension and aging. These studies will answer important questions about whether some of the well-documented cardio- and renal-protective effects of estrogen may occur via down-regulation of AT_1 receptors in the adrenal and kidney, two key effector organs of the RAS.

Glucocorticoids Alter the Birth and Death of Osteoblasts (NIAMS)
This study will characterize the effects of chronic glucocorticoid excess on several aspects of bone physiology. Patients with glucocorticoid-induced bone loss will be included. The effect of alendronate (Fosamax) and parathyroid hormone will be tested in mice for efficacy in ameliorating the effect of glucocorticoids.

Improving Antidepressant Adherence in Older Adults (NIMH)
The goal of the research within this Research Scientist Award is to provide further interdisciplinary training and research opportunities to transition the applicant to become an

independent investigator in interventions research. The career goal of the applicant is to develop interventions to improve adherence to antidepressant treatment among depressed older adults in primary care. The career development objectives of this application are to learn: 1) the theories underlying behavioral change interventions; 2) the design and evaluation of interventions in late-life depression; 3) assessment of older adults' attitudes and beliefs; and 4) factors that affect treatment adherence across illness. This training will provide the knowledge and skills to assess and to address negative attitudes and beliefs about: 1) depression and the usefulness of treatment efficacy, 2) stigma, and 3) treatment self-efficacy. The research proposed will pilot the usefulness of a brief, individualized intervention to improve adherence to SSRI antidepressant therapy by older adults prescribed by Primary Care Physicians. The intervention is designed to improve adherence by addressing the negative attitudes and beliefs that are obstacles to adherence for adults with late-life depression. Although the intervention is not a therapy to reduce depression, but because depression itself can contribute to negative attitudes and beliefs, one of the goals of the intervention is to buffer the effect of depression on adherence. The intervention targets obstacles to adherence and if proven useful, would be a manualized and feasible way to reduce the personal and public health costs of undertreatment of late-life depression in older adults seen in primary care.

Incidence of Late Macular Degeneration in Older Women (NEI)
Age-related macular degeneration (ARM) is the number one cause of irreversible blindness in the United States and is more prevalent in older, Caucasian women. Although there have been several studies on the incidence of ARM, none of these studies has been able to provide accurate estimates on the incidence of late ARM and/or the progression of ARM in the oldest old (those individuals over 80 years of age), because of the limited sample sizes in these studies in this age group. The population in the Study of Osteoporotic Fractures (SOF) is an appropriate cohort in which to evaluate the incidence of late ARM and the progression of ARM, because the mean age of the women at the re-examination will be 84.4 years of age and the sample is mainly Caucasian. The proposed research study aims to determine the incidence of late ARM, the rate of progression of ARM, and the association of specific risk factors such as diabetes mellitus and prior cataract surgery with late ARM and the progression of ARM in elderly women. In addition, it aims to determine the trajectory of visual decline in older women over a 14- year period. Secondarily, it aims to determine the impact of late ARM on vision-targeted health-related quality of life and to determine whether or not an association exists between the progression of ARM and the risk of falling and hip/non-spine fractures.

Low-Dose Doxycline Effects on Osteopenic Bone Loss (NIDCR)
This study seeks to demonstrate the clinical efficacy of low dose doxycycline (LDD) therapy in reducing bone loss due to periodontitis and estrogen deficiency in a postmenopausal estrogen deficient osteopenic population. Success in reducing or arresting bone loss related to periodontitis in an estrogen deficient osteopenic group would represent important progress in understanding and managing the pathophysiologic mechanisms that are involved in bone loss with this process.

National Academy of Sciences/National Research Council (NAS/NRC) Panel on Risk and Prevalence of Elder Abuse and Neglect (NIA)
The purpose of this initiative is to request NAS/NRC to organize a Panel on Risk and Prevalence of Elder Abuse and Neglect. The panel meetings will integrate expert knowledge in the field and provide advice on developing the methodology and design for a national probability sample on abuse and neglect. It will also suggest instrumentation for measuring highly sensitive and stigmatized behaviors and provide cross-fertilization for studies of child abuse, HIV, violence against women, and criminal behavior. NAS/NRC's Committee on National Statistics (CNSTAT) will be asked to provide expertise in the design of surveys to measure low prevalence phenomena in such populations as older, institutionalized women. A panel will help develop options for the research design, specify appropriate populations for sample inclusion (e.g., men, women, the institutionalized, racial/ethnic categories), and design instrumentation that can be used to detect incidents of elder abuse and neglect reliably and validly. The panel will evaluate the potential for pilot studies needed to develop instruments that can detect abusive behavior. The panel will also discuss issues related to confidentiality and data sharing. In addition, the panel will be asked to make recommendations regarding the scope of a national research effort on elder abuse and neglect which will include institutionalized victims of abuse and neglect and issues related to data collection on victims suffering from dementia.

New Methods for Monitoring Treatment for Osteoporosis (NIAMS)
The overall goal of this project is to develop improved monitoring methods for evaluating the success of a treatment on an individual patient basis using patient-specific estimates of the probability of non-response to treatment, or its complement, the probability of response to treatment. This will provide an empirically grounded and conceptually sound statistical tool for monitoring success of treatment for osteoporosis. This project will extend recently published work in this area, which was focused on the use of a patient's pre to post treatment change in total hip bone mineral density (BMD) for judging whether or not the patient has responded to treatment with alendronate. The procedure was calibrated with data from the Fracture Intervention Trial (FIT), a randomized placebo-controlled trial, which evaluated alendronate for treatment of osteoporosis. Application of the methods to FIT data and the Multiple Outcomes of Raloxifene Evaluation (MORE) data will provide new substantive results that will 1) contribute to useful clinical guidelines for judging how well a patient is responding to osteoporosis treatment and 2) provide guidance about cost-efficient patient-monitoring strategy.

Osteo-Arthritis Initiative (OAI) (NIAMS)
The OAI is a public-private partnership that will bring together new resources and commitment to help find biological markers for the progression of osteoarthritis, a degenerative joint disease that is a major cause of disability in people 65 and older. Over 5-7 years, the OAI will collect information and define disease standards on 5,000 people at high risk of having osteoarthritis and at high risk of progressing to severe osteoarthritis during the course of the study. Currently, new drug development for osteo-arthritis is hindered by the lack of objective and measurable standards for disease progression by which new drugs can be evaluated. The OAI consortium includes public funding from the National Institutes of Health (NIH) and private funding from several pharmaceutical companies: GlaxoSmithKline, Merck, Novartis Pharmaceuticals Corporation, and Pfizer. The consortium is being facilitated by the Foundation for the National

Institutes of Health, Inc. The OAI will provide approximately $8 million yearly for as many as six clinical research centers to establish and maintain a natural history database for osteoarthritis that will include clinical evaluation data and radiological images, and a biospecimen repository. All data and images collected will be available to researchers worldwide to help quicken the pace of scientific studies and biomarker identification.

Physical Activity in Older Rural Midwestern Women (NINR)
The purpose of this cross-sectional study is to describe the physical activity behavior (household, work/volunteer, leisure) determinants of physical activity, and cardiovascular risks (BMI and PB) in older (65-85 years), women with at least one chronic illness, residing in rural communities in the Midwest. The background determinants (demographics, environmental resources, social influence, and current health) and intrapersonal determinants (motivation [intrinsic motivation and barrier self-efficacy], cognitive appraisal [illness cognition], and affective health) of physical activity will be explored in relation to physical activity behavior and cardiovascular risks as guided by a modification of the Model of Physical Activity Behavior (MPAB). Subjects will include older rural volunteer women who are cognitively intact, self-described as able to perform physical activity, English speaking and who have at least one chronic illness. Recruitment will proceed through flyers, newspaper notices, and key informants in a rural, low income, Midwest County. The face to face questionnaire, administered in their homes or a location of their choosing, will include measures of background and intrapersonal determinants of physical activity. Physical activity will be measured with the Older Adult-Exercise/Physical Activity Inventory. Additionally, BMI will be determined with a weight and height scales and BP will be measured by an automated Omron 6006 monitor. Model development will proceed by systematically evaluating all the proposed relationships within the MPAB.

Predicting Onset Age and Length of Menopausal Transition (NIA)
Because of greater life expectancy today, menopause and its physiological consequences are having an enormous impact on the well-being of the older female. The present research is concerned with identifying, elucidating, and quantifying the ovarian and neuroendocrine mechanisms underlying menopause. In particular, to establish that there is a specific sequential pattern of five phases that occurs during the menopausal transition, and to construct statistical predictors of the onset age and duration of the menopausal transition. Moreover, such a predictor will also allow for the estimation of a given subject's "hormonal-reproductive age", not chronological age, which has enormous implications for the infertility consequences of aging. The ability to predict the age and length of the menopausal transition is clinically important because early menopause has associated with it increased risk of cardiovascular disease and osteoporosis, whereas late menopause has associated with it an increased risk of breast cancer and endometrial cancer. This research consists of three components. First, five prospective and cross-sectional clinical studies specifically designed for the above aims will be conducted at the University of Virginia GCRC, using pre-, peri-, and postmenopausal subjects. Second, a biomathematical model for the aging hypothalamic-pituitary-ovarian axis will be developed which includes its several feedback/feedforward interactions, the dynamical onset and shutdown of the LH surge and ovulation, as well as its eventual cessation. Third, based upon the preceding two, hypotheses concerning the five phases will be tested, and predictors of onset age and duration constructed.

Relationship of Morbidity and Mortality Between Spouses (NIA)
Employing the perspective and methods of the demography, the relationship between the morbidity and mortality of spouses will be examined. Questions about how the morbidity and mortality of one spouse, and the timing and nature of that morbidity and mortality affects the morbidity, mortality, and timing and nature of morbidity and mortality in the other spouse will be asked. For example, is the hazard of death in one spouse (the "proband") increased by illness or death in the other spouse? If so, how does the proband's hazard of illness or death change over time after the onset of illness or death in the spouse? And how do these effects vary according to the type of severity or duration of the spouse's morbidity? Do particular illnesses in spouses place probands at particularly high risk of developing illness or dying themselves? What role do sociodemographic factors play in all these effects? To address these questions most effectively, a new panel data set with demographic, socioeconomic, and health information about one million elderly married couples followed up to ten years will be created. Using a variety of event history and fixed effects methods, four main analyses will be conducted. First, how morbidity in one spouse influences mortality in the other will be evaluated. Individuals married to unhealthy spouses will have worse mortality than those married to healthy spouses and that the longer the spouse is ill, the greater the effect is the working hypotheses. Certain types of spousal morbidity (e.g., those that most compromise activity levels) will be worse for probands is also hypothesized. Second, the widower effect (i.e., the increased tendency of the bereaved to die) with adjustment for the health of both spouses prior to widowhood will be evaluated; examine its temporal shape in detail; and assess its dependence on socioeconomic factors. Third, the principle investigator will evaluate how morbidity in one spouse influences morbidity in the other. Are healthy spouses better able than unhealthy spouses to provide health benefits in marriage? Fourth, the impact of widowhood on the morbidity, and not just mortality, of bereaved spouses will be evaluated. This work advances the demography of aging by: closely examining how an individual's morbidity and mortality are affected by the presence or absence of spousal support; focusing on cause-of-death specific aspects of demographic phenomena; examining theoretically interesting sub-populations along gender race, socioeconomic, and health status lines; and shedding light on the mechanisms of inter-spousal health effects. This work also has policy implications in that it: supports more accurate projections of the health burdens in the elderly, facilitates targeting of support services to the growing numbers of widowed elderly; and addresses important populations, such as minorities, the poor, the oldest old, those with dementia, and caregivers.

Look AHEAD: Action for Health in Diabetes (formerly Study of Health Outcomes of Weight Loss) (NIDDK)
Sixteen centers across the U.S. are participating in a randomized controlled clinical trial that involves 5,000 overweight and obese individuals with type 2 diabetes. Look AHEAD will examine the long term health effects of interventions designed to produce sustained weight loss as compared to a diabetes support and education program. Participants in both arms of the study receive diabetes care from their primary care physicians. The primary outcome of Look AHEAD is the impact of the interventions on heart attack, stroke and cardiovascular-related death. Look AHEAD also will be examining the effects of the interventions on cardiovascular procedures, mortality, diabetes progression, cardiovascular risk factors, bone density, quality of

life and costs. Participants in the study will be followed up for 9 to 11.5 years total, depending on the date of enrollment. Recruitment into Look AHEAD is anticipated to end in April, 2004.

Study of Women's Health Across Nation II: (SWAN II) (NIA)
SWAN consists of both cross sectional and longitudinal studies on the natural history of menopause and a characterization of endocrinology/physiology of premenopause. Five ethnic groups are included - Caucasian, African American, Hispanic, Chinese, and Japanese. There are 7 sites across the country - Boston, Pittsburgh, Chicago, Michigan, UCLA, UC Davis and New Jersey. For the cross-sectional study, there are approximately 16,000 women enrolled ranging in age from 40-55 years to determine the age of menopause. The longitudinal study has approximately 3150 women (450 at each site) between the ages of 42-52 to determine menopause-specific physiological changes and their predictors and the impact of menopause on subsequent disease. Measurements are being made of the major reproductive axis hormones (LH, FSH, estradiol, progesterone, and testosterone), adrenal markers of aging (DHEAs), other endocrine markers (TSH, sex hormone binding globulin [SHBG]) and new ovarian markers which have the potential to define the menopausal transition and the postmenopause.

Symptom Intervention for Older Women with Breast Cancer (NINR)
Older women, especially those over age 75, are the fastest growing segment of the population. Many of these women will be living with breast cancer because the incidence of this disease increases with age. Unfortunately, the research on adaptation to illness, symptom management, and quality of life of women with breast cancer has focused on women under 65. Unlike younger women, older women with breast cancer experience symptoms of their disease and its treatment concurrent with symptoms of age-related chronic illnesses. Thus, they are faced with the unique challenge of sorting out and managing a variety of complex and sometimes confusing symptoms. This study proposes to test an individualized representational intervention (IRIS) to improve symptom management and quality of life in older women with breast cancer. Participants in this study will be women aged 65 and older who are at least one year post-diagnosis of breast cancer. They will be randomized to one of three conditions: a representational intervention (IRIS) delivered by an advanced practice nurse in a counseling interview, an attention-only control group, or usual care. Measures of symptom distress, helpfulness of symptoms management activities, and quality of life will be taken at baseline, six weeks and ten weeks post intervention. The investigators predict that IRIS will improve symptom management, which will in turn improve quality of life for older women with breast cancer.

Urine Loss and Prolapse in Nuns and Their Parous Sisters (NICHD)
Urinary incontinence (UI) and pelvic organ prolapse (POP) are common health problems in older women, for which the etiologies are poorly understood. Injuries to the pelvic floor at the time of vaginal delivery and genetic predisposition have been implicated as factors associated with UI and POP. However, the epidemiological evidence for these relationships is scant and controversial. Data from the investigators survey study of 149 nulliparous nuns found the same prevalence of stress urinary incontinence (SUI) as was reported for parous women. The major objective of this proposed study is to determine whether vaginal delivery and familiality are associated with the development of urinary incontinence and pelvic organ prolapse by comparing the prevalence of objectively confirmed incontinence and prolapse in nuns (nulliparous women) with the corresponding rates in their biological sisters who have had at least one vaginal delivery.

The data collected will be tested in a matched pair analysis. It will be determined whether nulliparous nuns differ from their biological sisters with regard to UI and POP. A matched pair logistic regression will be performed to obtain an adjusted estimate of the impact of familiality and vaginal delivery in UI and POP, taking into account other risk factors.

Older Adults, Health Information and the World Wide Web Conference

The Older Adults Health Information and the World Wide Web (WWW) Conference sponsored by SPRY Foundation "Helping People Age Successfully" at NIH brought together leaders in the fields of technology, aging, policy and health to: identify the basic applied cognitive and behavioral research being conducted to increase the use of computers and the Web by older adults, their caregivers and health service providers; identify key impediments that older adults face as they use the WWW to access health information; and present possible solutions to these impediments through a cross-fertilization of ideas between researchers in cognition, aging, computer use and design, and health information providers; and address current issues on presenting quality health information on the WWW to older adults and their caregivers.

National Eye Institute

Age-Related Macular Degeneration

Age-related macular degeneration (AMD) is the leading cause of irreversible vision loss in the United States among persons over 65. The condition affects the retina and leads to varying degrees of vision loss depending on the form and severity of the disease. The National Eye Institute (NEI)-sponsored Age-Related Eye Disease Study (AREDS) was designed to study the clinical course of AMD and to evaluate the effects certain nutrients have on the development and progression of this disease. The AREDS enrolled 4,757 participants, 55 to 80 years of age, in 11 clinical centers nationwide. Participants in the study were given one of four treatments: 1) zinc alone; 2) antioxidants alone; 3) a combination of antioxidants and zinc; and 4) placebo. Researchers conducting the study found that people at high risk of developing advanced stages of AMD lowered their risk of advanced development of the disease and its associated vision loss by about 25 percent when treated with a high-dose combination of antioxidant vitamins C, E, and beta-carotene, and the trace element zinc. In the same high risk group, high doses of nutrients alone reduced the risk of vision loss caused by advanced AMD by about 19 percent. The demonstration that high levels of antioxidant nutrients and zinc significantly reduce the risk of advanced AMD and its associated vision loss is particularly important because these nutrients are the first effective treatment shown to slow the progression of this disease. This treatment plays a critical role in keeping people at high risk from progressing to the more advanced stages that result in serious loss of vision.

Aging-Related Cataracts

Age-related cataract formation is believed to result from the complex effects of aging on normal physiological processes. Because the end-result, cataract formation, is in most cases far removed in time from the initial insult, exacting a cause and effect relationship has been difficult. It has long been recognized that lens transparency results from the very high concentration of soluble

proteins, the crystallins, within a specialized lens fiber cell. It has also long been known that there is little turnover of proteins within these cells. An adult lens contains proteins synthesized at the earliest stages of embryological development, making fiber cell proteins especially susceptible to the effects of aging. During aging and cataract formation, soluble lens crystallins tend to combine or aggregate into large complexes that cause light to scatter. The normal lens counteracts this aggregation process through the function of á-crystallin, which acts as a molecular chaperone, preventing the unfolding and aggregation of proteins. New research provides data linking the formation of high molecular weight crystallin complexes with diminished chaperone activity. Scientists examined lenses during aging and cataract formation. They found that as á-crystallin acts to prevent the deleterious effect of aggregate formation by binding to other proteins, á-crystallin itself becomes incorporated into an aggregate. Since á-crystallin strongly binds to the lens fiber cell membrane, it becomes a vehicle for complexes to accumulate at the membrane, allowing further damaging physiological effects that may accelerate cataract formation. These new data also showed that the á-crystallin in this membrane-bound aggregate has a significantly diminished capacity to function as a chaperone, indicating that its protective effect has been neutralized. These new studies suggest a possible mechanism of cataract formation. This finding also suggests additional research in this area may provide the means for clinicians to intervene prior to the formation of a clinically evident cataract.

Glaucoma

Glaucoma is a group of eye disorders which share a distinct type of optic nerve damage that can lead to blindness. Elevated intraocular pressure is frequently, but not always, associated with glaucoma. Glaucoma is a major public health problem and the number one cause of blindness in African Americans. Approximately 2.2 million Americans have glaucoma, and a similar number are unaware that they have the disease. As many as 120,000 people are blind from this disease in the U.S. Most of these cases can be attributed to primary open angle glaucoma, an age-related form of the disease.

Even though glaucoma was first described over 100 years ago, there is no complete understanding of its pathogenesis. The hallmark of glaucoma is a distinct pattern of optic nerve degeneration. This degeneration is most commonly associated with elevated intraocular pressure; however, in some patients an elevation in pressure is not evident on clinical examination. Scientists have recently identified a human gene, OPTN, that is linked to a disease known as "low-tension" glaucoma. In patients with this form of the disease, clinicians are unable to detect pathological elevations of intraocular pressure. Four separate mutations in this gene were identified in families in which "low-tension" glaucoma was known to be inherited. Further screening of glaucoma patients suggested that mutations in OPTN may be a risk factor for "low-tension" glaucoma patients. This gene encodes the protein optineurin, which is expressed in a number of tissues including the brain and retina. Optineurin has been shown to interact with other brain proteins such as huntingtin, the protein responsible for Huntington's disease and therefore may have a significant neurological function. Other studies suggest that optineurin participates in a signal transduction pathway involving tumor necrosis factor-alpha, a factor that is believed to increase the severity of optic nerve damage in glaucoma. Increasingly, scientists have viewed protecting the optic nerve as the key to treating the disease. The identification of OPTN as a glaucoma gene provides a tool to study the biochemical pathways

leading to optic nerve degeneration, as well as giving insight into designing neuroprotective strategies.

Researchers working on the NEI-supported Ocular Hypertension Treatment Study have also discovered that eye drops used to treat elevated pressure inside the eye can be effective in delaying the onset of glaucoma. These scientists found that pressure-lowering eye drops reduced the development of primary open-angle glaucoma (POAG) by more than 50 percent. The study also identified several significant risk factors that were associated with the development of glaucoma in study participants. These included personal risk factors, such as older age and African descent, as well as ocular risk factors, such as higher eye pressure, certain characteristics in the anatomy of the optic nerve, and thinness of the cornea. These results mean that treating people at higher risk for developing glaucoma may delay or possibly prevent the disease.

Another NEI-supported study, The Early Manifest Glaucoma Trial, was designed to compare the effect of immediate therapy to lower the intraocular pressure (IOP) versus late or no treatment on the progression of newly detected open-angle glaucoma. The study followed 255 patients, aged 50-80 years, with early stage glaucoma in at least one eye. One group (129 patients) was treated immediately with medicines and laser to lower eye pressure, and a control group (126 patients) was untreated. Both groups were followed carefully and monitored every three months for early signs of advancing disease, using indicators that are extremely sensitive for detecting glaucoma progression. Any patient in the control group whose glaucoma progressed was immediately offered treatment. After six years of followup, scientists found that progression was less frequent in the treated group (45 percent) than in the control group (62 percent), and occurred significantly later in treated patients. Treatment effects were also evident in patients with different characteristics, such as age, initial eye pressure levels, and degree of glaucoma damage. In the treated group, eye pressure was lowered by an average of 25 percent. This finding supports the medical community's emerging consensus that treatment to lower pressure inside the eye can slow glaucoma damage and subsequent vision loss.

Low Vision Education Program

The EYE SITE is an interactive educational exhibit on low vision that consists of five colorful kiosks ranging in height from 6 to 8 feet, and is designed to attract a cross section of the population, from young people to senior citizens. It contains an interactive multimedia touchscreen program; provides information on low vision services and resources; and displays aids and devices that help people with low vision. This traveling exhibit is designed for use in shopping centers and other high traffic consumer venues.

The exhibit and touchscreen program explain the causes of low vision, offer personal accounts of people living with low vision, and provide a self-assessment to help people determine whether they or someone they know may have low vision. A highlight of the touchscreen program is an animated character (called ELVEE) who guides the viewer through the program, as well as several short videos that provide "hands-on" advice.

National Institute of Neurological Disorders and Stroke

The National Institute of Neurological Disorders and Stroke (NINDS) supports research on the brain, spinal cord and the nervous system. Many disorders of the nervous system appear more commonly in older individuals; these include stroke, Parkinson's disease (PD), and Alzheimer's disease (AD). Other neurological conditions, such as epilepsy and traumatic nervous system injuries, impact many young people, but present special problems as affected individuals grow older. For these reasons, a great deal of the research supported by NINDS is directly or indirectly relevant to the aging population.

Stroke

Stroke research is a high priority of NINDS because of both the enormous public health burden and the scientific opportunities for progress. More than 700,000 strokes, caused by the blockage of blood flow (ischemic stroke) or bleeding (hemorrhagic stroke) into the brain, occur in the United States each year. Stroke is the third leading cause of death and a major cause of disability in the U.S. As with PD and AD, increasing age is a risk factor for stroke. It has been reported that the chance of having a stroke more than doubles for each decade of life after age 55.

Stroke Progress Review Group

The large body of research knowledge acquired over the years, coupled with new technologies, is providing a wealth of new scientific opportunities. At the same time, increasing research needs and scientific opportunities required that the NINDS determine the best uses for its resources. In order to address these issues, NINDS convened a group of leading stroke experts, called the Stroke Progress Review Group (SPRG), to develop a national plan for basic and clinical research in stroke. In 2001, the SPRG held a meeting of 150 nationally and internationally recognized stroke experts to identify gaps in stroke knowledge and set research priorities. As a result of this Roundtable meeting, the SPRG issued an exciting report reflecting the energy and enthusiasm of the clinical, research, industrial, and advocacy communities for identifying effective prevention strategies and treatments for stroke.

The comprehensive report from this meeting will serve as a guide for planning research in stroke prevention, diagnosis, treatment and rehabilitation for the coming years. An internal NINDS Stroke Working Group, made up of representatives from several extramural program clusters, is meeting regularly to assist in the implementation of the recommendations.

Program Activities

NINDS is engaged in a broad range of activities, from fundamental research on how stroke damages brain cells, to the design of large-scale clinical trials of therapeutic agents and targeted programs of public education and prevention. The Institute has also established a repository for the collection of DNA from individuals with stroke and several other neurological conditions.

In addition to these activities, the NINDS has initiated a new program called the Specialized Program of Translational Research in Acute Stroke (SPOTRIAS). The objective of this innovative model is to facilitate translation of basic research findings into clinical practice. This is done in settings where patients with acute ischemic and hemorrhagic stroke are evaluated and treated very rapidly after the onset of their symptoms. The intent of the SPOTRIAS is to support

a collaboration of clinical researchers from different specialties whose collective efforts will lead to new approaches to early diagnosis and treatment of acute stroke patients. Training and career development are part of the SPOTRIAS program.

Research Findings

Stroke "Vaccine"
An NINDS-funded study, focusing on the immune system, has developed a "vaccine" strategy that interferes with a critical step in inflammation inside blood vessels, and greatly reduces the frequency and severity of strokes in a strain of hypertensive, stroke-prone rats. The scientists administered a nasal spray containing E-selectin, which programmed white blood cells to monitor blood vessel linings for this protein, and thus for inflammation. On detecting the molecule, the lymphocytes released substances that suppress inflammation. The procedure potently prevented both ischemic and hemorrhagic strokes. Planning is underway for a Phase I trial of E-selectin in people at high risk for stroke. More generally, these findings reinforce the importance of the immune system and inflammation in stroke, and support the idea that strategies to modulate the immune system may be a useful strategy for preventing stroke.

High Blood Sugar and Mortality After Stroke
A recent study of stroke patients found that those with high blood sugar were at a higher risk of dying between one month and five years after their stroke. They also had longer hospital stays and higher hospital costs than did patients with normal blood sugar levels. A pilot trial, funded by the NINDS, is now underway to determine the safety and effectiveness of intravenous insulin treatments to control blood sugar and improve outcome in stroke patients.

Stroke Education Efforts

The NINDS leads the Brain Attack Coalition, an umbrella organization of several national organizations that are working together to launch a major stroke education campaign called ***Know Stroke. Know the Signs. Act in Time.*** The *Know Stroke* campaign is a multi-faceted public education program designed to raise awareness of the signs and symptoms of stroke and the need to act quickly to seek medical care. It includes public service advertising, media outreach and community education. Through a variety of voluntary organizations and Federal partners, NINDS has distributed hundreds of thousands of brochures and posters and more than 1,000 community education kits. These organizations are using *Know Stroke* materials in educational sessions at hospitals, senior centers, and other places that serve those at the highest risk for stroke.

Parkinson's Disease

Parkinson's disease is a relatively common movement disorder resulting from the loss of dopamine-producing brain cells. This neurological condition affects more than 500,000 Americans at any given time. Although the disease can be diagnosed in young people, the majority of those affected are over the age of 50. With many of these individuals surviving for a number of years after their diagnosis, the complications that arise as a result of treatment

strategies, and the normal progression of the disease have a significant impact on the quality of life in older people with this disorder.

Program Activities

NINDS has supported PD research for many years, but has given special focus to its PD programs since the development of the NIH Parkinson's Disease Research Agenda in 2000. The NINDS has led the NIH in the implementation of the Agenda, which has involved the release of dozens of grant and contract solicitations, the sponsorship of multiple workshops, and a broad-based effort to coordinate activities with other Federal agencies and private funding organizations in the PD community. Recent solicitations have focused on gene therapy, gene discovery, deep brain stimulation, dyskinesias, and the cognitive problems experienced by individuals with PD. The NINDS also issued a Program Announcement, with the National Institute of Environmental Health Sciences, to continue the Morris K. Udall Parkinson's Disease Research Centers of Excellence program; jointly developed a "fast-track" initiative with several PD voluntary groups; and established a repository for the collection of DNA from individuals with PD and several other neurological conditions. In 2001-2002, the Institute also made exceptional progress in developing the infrastructure for a large series of clinical studies designed to evaluate potential neuroprotective therapies for Parkinson's disease.

In addition to these activities, NINDS has organized two strategic planning meetings as part of the implementation of the PD Research Agenda: the first, in January 2002, involved PD researchers and members of the voluntary community. These participants evaluated progress to date on the PD Research Agenda, and identified several emerging areas of science that warranted additional attention. The second meeting – a Parkinson's Disease Coordination Summit – was convened at the request of the NIH Director in July 2002. It involved a small group of scientists who were asked to evaluate the international portfolio of PD research, and to make recommendations about new opportunities and/or identify roadblocks that may be impeding research progress. The recommendations that emerged from this second meeting enabled NINDS to develop a matrix of short-to-long term and low-to-high risk goals that will guide the implementation of the PD Research Agenda over the next several years.

Research Findings

Preclinical Success with GDNF

In a recent study, NINDS-supported researchers have demonstrated that the direct infusion of glial cell-line derived neurotrophic factor (GDNF; a growth factor that has a profound impact on the survival and outgrowth of some types of dopamine neurons) into regions of the brain affected by PD can have beneficial effects on primates with chemically-induced parkinsonism. The GDNF, delivered chronically via an implanted pump, improved motor function and restored several aspects of the dopamine system in these animals. These animal studies provided information that was critical for the development of clinical trials using this approach.

Stem Cell Transplantation

NINDS intramural researchers have recently obtained encouraging results with mouse embryonic stem cells. They demonstrated that by driving a specific pathway of gene expression and

applying other specific chemical signals, these cells can be influenced to develop into dopaminergic neurons in culture. The cells in turn can be transplanted into a rodent model of PD, where they appear to survive, integrate with the host tissue, and reverse some motor impairments. Similarly promising results have also been obtained by extramural researchers who have transplanted low doses of undifferentiated mouse embryonic stem cells into an area of the rat brain that has been implicated in PD. They found that these cells could successfully develop into dopaminergic neurons, integrate with the host tissue, and reverse asymmetric motor deficits characteristic of at least one type of rodent PD model.

Gene Therapy

Several different approaches to gene therapy - including a variety of delivery methods and agents to be delivered - have been considered in attempts to reverse the neurological deficits in animal models of parkinsonism. Delivery of the gene for tyrosine hydroxylase (an enzyme responsible for synthesizing dopamine) to the striatum (a region of the brain dramatically affected by PD) alone has only provided limited benefits in reversing parkinsonian deficits in rats. However, a recent NINDS-funded study suggests that this approach can provide long-lasting reductions in parkinsonian behaviors in a rodent model, if the enzyme responsible for producing a necessary co-factor is also delivered via gene transfer.

Protein Assembly and Neurodegeneration

The protein alpha-synuclein, known to be altered in some familial forms of parkinsonism, forms abnormal clumps in the brains of people with Parkinson's disease. A recent NINDS-supported study examined the role of alpha-synuclein fibrils (a type of protein strand) in the disease process. The results indicated that the stabilization of an early-stage alpha-synuclein fibril (the "protofibrillar" form) could promote the development of PD. Surprisingly, the researchers found that both dopamine, and L-dopa (the drug used in PD to replenish dopamine), could have this stabilizing effect. This finding may not only help researchers design more effective treatments for PD, but it may also help them to understand why long term dopamine therapy can cause severe side effects.

Alzheimer's Disease

One of the emerging themes in the study of AD, PD, and other neurodegenerative diseases is the overlap that researchers have observed in their pathology. Specifically, we are finding that many of these disorders may be caused by similar abnormalities in protein folding and accumulation. As a result, every new finding in one of these diseases has the potential to impact the study of other neurodegenerative conditions, making NINDS support of AD research more relevant than ever.

Program Activities

In addition to supporting its own portfolio of AD research, the Institute often collaborates with other NIH Institutes and Centers on grants solicitations and workshops of mutual interest. For example, NINDS and NIA have co-sponsored workshops on the neuropathology of degenerative diseases and on brain banking. NINDS also joined NIA on its release of the grant solicitation on "Collaborative Studies on Alzheimer's Disease and Other Neurodegenerative Diseases Associated with Aging" in December 2002. The purpose of this Request for Applications was to

facilitate collaborative cross-disciplinary and multi-institutional approaches that will contribute new and vital information about the clinical and pathological course of normal aging and the neurodegenerative diseases associated with aging.

Research Findings

Relationship of Plaques to Tangles in AD Pathology
Both amyloid plaques and neurofibrillary tangles of abnormally modified tau proteins are cellular hallmarks of AD, but the relationship between amyloid and the changes in tau proteins has not been well understood. In a recent study, investigators supported by NINDS, NIA and the Alzheimer's Association have found that neurons containing either human or mouse tau proteins degenerated if exposed to fibrillar amyloid-beta. However, neurons from mice genetically engineered without tau did not degenerate under these conditions. These results suggest that the effects of amyloid-beta on the degeneration of neurons in AD may be mediated to some degree by the tau proteins.

In order to fully understand the relationship between amyloid plaques and neurofibrillary tangles in the development of AD, an animal model that reproduces both abnormalities could be extremely helpful to researchers. A recent study funded by NINDS, NIA and other organizations, has shown that it is possible to generate such a model in the mouse. Not only are these animals helpful in terms of understanding how mutant proteins interact and contribute to cell death, they are also useful for the testing of potential therapeutic agents at the behavioral and cellular levels.

New Mutation Affects Amyloid-beta Processing
The study of families with inherited mutations in the amyloid precursor protein gene has revealed extensive information about the biological basis of AD. Specifically, the location of different mutations appears to have a direct effect on the nature of amyloid-beta fibrillization in affected individuals, which in turn may impact the clinical features of their particular disease. In a recent study funded by NINDS, NIA, and other organizations, researchers provided evidence for a new mutation discovered in a Swedish family with a history of the disorder, which may lead to a novel form of amyloid-beta processing. Findings in families such as this one are often extremely helpful to researchers in terms of understanding the cellular mechanisms that contribute to the development of AD.

National Institute of Environmental Health Sciences

The National Institute of Environmental Health Sciences (NIEHS) explores the environmental factors that contribute to human disease, especially the interaction between environment, susceptibility, and time over the age span. Understanding of these interactions is a key step in promoting seniors' health, which manifests the influences of a lifetime of environmental exposures. Research on the effects of the environment on aging and diseases of aging has been increasing for the past few years at the NIEHS, especially in the area of environmental factors in Parkinson's disease (see below.)

Additionally, NIEHS grantees are working to determine how various environmental exposures affect the development of assorted diseases in the later stages of life. For example, in three separate studies researchers are examining the effects of lead, methylmercury, and aluminum exposure and the development of chronic diseases such as hypertension and decreased cognitive functioning. Determining the consequences of these exposures, especially related to cognitive function through the aging process, will help understand how to provide therapies and intervention strategies to reduce harmful health impacts.

Parkinson's Disease

In response to the accumulating evidence for significant environmental influences in PD, and the likely role of gene-environment interactions in disease etiology, NIEHS developed and launched a major new research initiative in 2002, the Collaborative Centers for Parkinson's Disease Environmental Research (CCPDER) Program. This Program seeks to strengthen the integrative collaboration among scientists engaged in fundamental laboratory research in PD and geneticists, clinicians and epidemiologists, allowing leads uncovered in one area to be pursued quickly in others. Historically, such integration has provided some of the most significant advances in the field of Parkinson's disease.

The centerpiece of the CCPDER Program is a highly interactive national network of three research Centers that function to share data and resources and engage in the planning and conduct of collaborative studies relevant to environmental factor causation in PD. In addition to its role in the larger network, each CCPDER is engaged in a self-contained program of research activities that focus on gene-environment interactions in PD. An essential component of the CCPDER Program is active involvement of the lay PD lay advocacy community. This is achieved in several ways, including participation of advocates as members of External Advisory Boards of each CCPDER and through planned collaborative design and evaluation of a CCPDER website that facilitates information exchange with the PD scientific and lay communities.

The three main research objectives of the CCPDER Consortium Program are to:

identify genetic and environmental factor interactions that contribute to PD.
provide a mechanistic understanding of how gene-environment interactions trigger the pathophysiological processes that ultimately produce PD.
develop the knowledge base to enable translation of research findings into rational prevention and intervention strategies for PD.

The Request for Applications (RFA) for the CCPDER Program was published in the NIH Guide in December 2001. Five-year awards, totaling 20 million dollars, were made in August 2002 to three Centers, located at the Parkinson's Institute, Emory University, and the University of California at Los Angeles. One common theme of these Centers is the role of pesticides and other agrichemicals as risk factors for PD and the interaction of these compounds with mechanisms that regulate levels of the neurotransmitter dopamine. The CCPDERs are funded through a cooperative agreement mechanism. This funding mechanism allows significant scientific and programmatic involvement of NIH staff in the conduct of the research and will facilitate the integration of the CCPDER program with other NIEHS and NIH programs and resources.

Safety of Herbal Medicines

Medicinal herbs are among our oldest and most widely used medicines, and their use is increasing. Approximately one third of the U.S. population is believed to use some form of alternative medicine, including herbal remedies; many of these are used for the treatment or prevention of disease in elderly people. Although approximately 1,500 botanicals are sold as dietary supplements or ethnic traditional medicines, herbal formulations are not subjected to FDA premarket approval to ensure their safety or efficacy.

The NIEHS/National Toxicology Program is planning or conducting research on several medicinal herbs–and compounds found in herbs–to examine carcinogenicity, neurotoxicity, immunotoxicity, or toxic effects associated with exposures to both high acute doses and low chronic doses. Among the herbs under study are several which are particularly associated with use by seniors: black cohosh (used to treat symptoms of menopause); ginseng (used to treat hypertension, diabetes and depression); gingko biloba extract (used to treat short-term memory loss) and others.

Selected Examples of Recent Research (2001-2002) Relevant to Aging

Heme Deficiency in Neurons Causes Metabolic Disruptions Similar to Alzheimer's Disease:
Normal aging of the brain and neurodegenerative changes share certain pathological and physiological changes including mitochondrial dysfunction, oxidative stress, and loss of iron homeostasis. Heme synthesis also declines with age. Heme is the major intracellular functional form of iron. It is synthesized in the mitochondria and the decline in synthesis could explain the loss of iron homeostasis in aging. Heme functions in hemoglobin and in a variety of enzymes as well as promoting the growth of nervous tissue. Researchers induced heme deficiency in a nerve cell culture system and showed that heme deficiency was detrimental to normal mitochondrial function; it altered amyloid proteins, inhibited zinc and iron homeostasis, and stimulated oxidative stress by activating nitric oxide synthase. The metabolic changes seen during the heme deficiency were similar to those in patients with Alzheimer's disease.

Common reasons for heme deficiency are iron and vitamin B6 deficiencies, aging, and exposure to toxic metals such as aluminum. In addition, degradation of heme by heme oxygenase, which increases with age and in the brains of Alzheimer's patients, may be a factor in changes in the metabolism of iron and heme with age. Therefore, heme deficiency may be an important and preventable part of the neurodegenerative process, which deserves more research and attention.

Interaction of the Herbicide Paraquat with Alpha-Synuclein in PD:
Parkinson's disease is characterized by the loss of dopaminergic neurons in the nigrostriatal pathway and the formation of intraneuronal inclusions (called Lewy bodies) in different brain regions. Several lines of evidence suggest a key role of the protein alpha-synuclein. This protein is a major component of Lewy bodies in all PD patients and alpha-synuclein mutations have been associated with rare cases of familial parkinsonism. It has been hypothesized that a tendency of alpha-synuclein to aggregate may underlie its involvement in Lewy body formation and neurodegeneration. Researchers supported by the NIEHS have shown that administration of the herbicide paraquat dramatically accelerates the aggregation of alpha-synuclein in both in

vitro and in vivo models. Toxicant-induced aggregation of alpha-synuclein may provide a mechanism to explain the reported epidemiological associations between pesticide use and risk for PD.

National Institute of Allergy and Infectious Diseases

The National Institute of Allergy and Infectious Diseases (NIAID) supports and conducts basic and clinical research on several diseases and conditions that affect the health of older Americans. Several research initiatives are yielding advances in the understanding and treatment of these disorders.

Pneumococcal Disease
Streptococcus pneumoniae, also called pneumococcus, is a bacterium that infects the upper respiratory tract and can spread to the blood, lungs, middle ear, or nervous system. In the United States, S. pneumoniae causes 40,000 deaths, 7 million middle ear infections (otitis media), 500,000 cases of pneumonia, 50,000 blood stream infections (bacteremia), and 3,000 cases of meningitis annually. Pneumococcal disease kills more Americans each year than all other vaccine-preventable diseases combined. Adults 65 years old and older are among the people disproportionately affected by pneumococcal disease. Pneumococcal disease can be difficult to treat because it has become more resistant to drug treatment. This makes prevention of the disease through vaccination even more important. NIAID has conducted and supported research on pneumococcal vaccine development for more than 30 years.

Two Phase I/II trials were recently completed in a high risk population to determine what impact a multivalent pneumococcal conjugate vaccine has on safety and immunogenicity when administered to elderly individuals. Multiple injections of a 9-valent and an 11-valent pneumococcal conjugate vaccine were given to several hundred elderly individuals older than 65 years of age using several different vaccine schedules. Early results from both studies indicate that the conjugate vaccine is well tolerated and generates no greater local reactions than the licensed polysaccharide vaccine. In one of the studies in which individuals received the 11-valent vaccine, a challenge with the polysaccharide vaccine following a single dose of the conjugate vaccine demonstrated slightly higher antibody levels to 8 of 9 serotypes compared to individuals who first received 2 doses of the conjugate vaccine followed by the polysaccharide product or just the polysaccharide vaccine alone. The data suggest that a pneumococcal conjugate vaccine may prime for a more robust response to subsequent exposure to a licensed polysaccharide vaccine. Antibody data from the second trial is not yet available.

Shingles
Shingles (zoster) is caused by the same virus, varicella-zoster (VZV) that causes chickenpox (varicella). Primary infection with VZV manifests as chickenpox; after a latent period, reactivation of the virus leads to shingles. Current research is aimed at preventing shingles and shingles-associated pain in otherwise healthy older Americans.

Every year, 600,000 to one million Americans are diagnosed with shingles. A person has a one-in-five chance of developing shingles in his or her lifetime. More than half of shingles cases occur in persons 60 years or older, and the incidence and severity of shingles and its complications increase with increasing age. During the next 30 years, as the number of American seniors continues to increase, the need for a shingles vaccine will grow.

The Shingles Prevention Study (SPS) is a national trial of an experimental vaccine for the prevention of shingles and its complications in people 60 years or older. The SPS is being conducted by the Department of Veterans Affairs in scientific collaboration with NIAID and Merck & Co., the vaccine's developer. The trial reached its target enrollment of over 38,000 subjects in 2001, follow-up will be completed toward the end of 2003, and the final results of the study are expected to be available by mid-2004. The vaccine being studied is a more potent form of the same vaccine routinely given to children to prevent chickenpox.

Alzheimer's Disease
In Alzheimer's disease, a protein named amyloid ß for unknown reasons forms large aggregates in the brain that lead to progressive loss of mental function. NIAID immunologists have shown that amyloid ß is a potent and specific activator of a particular type of immune cell receptor named FPRL1R that is connected to both cell movement and to production of toxic forms of oxygen. The receptor was found to be concentrated on cells in the diseased brain areas in Alzheimer's patients. This receptor may explain how aggregation of this protein causes inflammation and disease.

National Institute of Biomedical Imaging and Bioengineering

The National Institute of Biomedical Imaging and Bioengineering (NIBIB) seeks to improve human health by supporting innovative research and training aimed at developing imaging, engineering, and informatics tools with broad medical utility in the diagnosis, treatment, and prevention of disease. NIBIB is particularly committed to fostering interdisciplinary efforts that combine the expertise of biomedical and physical scientists and engineers and to translating research findings rapidly into clinically useful applications. Several NIBIB projects are directly relevant to improving health care for older Americans.

New treatments for osteoporosis. In postmenopausal women, osteoporosis is a major cause of morbidity and mortality. For Caucasian women over 50, for example, the cumulative lifetime risk of fractures from osteoporosis is between 30 and 40 percent. Because osteoporosis is a chronic, but not life threatening, condition, patient compliance with treatment will be greatly enhanced if the therapeutic drug can be taken orally and elicits minimal side effects. NIBIB-funded investigators are working to develop a highly selective oral drug combination that will possess both of these properties. This new treatment will combine a hormone, calcitonin, which enhances bone formation while blocking bone resorption, with a second agent that blocks bone resorption by a completely different mechanism. A particularly compelling aspect of this research is a plan to engineer the physical properties of the drug combination to ensure delivery to the precise region of the cells involved in bone metabolism at which the drugs will exert their effects.

New imaging agents for Parkinson's disease. About 500,000 people in the U.S. are believed to suffer from Parkinson's disease. The average age of onset is 60, and incidence increases with age; Parkinson's is thus primarily a disease of the elderly. Parkinson's disease reflects the loss of neurons in the brain that use dopamine as a signaling agent. NIBIB is supporting investigators who are designing new series of imaging agents to facilitate the diagnosis of Parkinson's disease. These new chemical probes will interact selectively with dopamine neurons in living patients and will ultimately allow clinicians to diagnose Parkinson's disease with increased precision. In addition, the development of new imaging agents will impact significantly on the future expansion of new diagnostic procedures for other diseases and disorders and on the improvement of health care as a whole.

Bioengineering scaffolds for tissue repair. Arthritis is the most widespread debilitating disease in the U.S., and its prevalence increases with age. It has been estimated that nearly 50 percent of adults 55 and older are affected by this condition. The lower extremities are particularly subject to arthritic impairment, and artificial replacement of the knees and hips accounts for 50 percent of all implants. Although orthopedic implants improve patient function and reduce chronic pain, they often involve notably invasive surgical procedures that may require a hospital stay. Artificial joint implants have also been shown to alter a patient's perception of movement which can lead to an increased incidence of falls. A goal of the NIBIB research program is to develop a scaffold with a layer of functional cartilage on one surface that can be easily and noninvasively implanted into a joint to replace damaged tissue, precluding the need for artificial joint replacement. NIBIB researchers are currently engineering and testing tissue-covered scaffolds with implanted load sensors as replacements for damaged cartilage. This technology would both reduce the need for artificial joint replacements and provide the surgeon with a means for monitoring the rehabilitation and healing process.

Microsensors for detecting urinary infections. Urinary tract infections are 30 times more common in women than in men, and they are extraordinarily prevalent in the postmenopausal population. Incidence also increases in men over the age of 50 years due to an increased frequency of prostate disease. Scientists supported by the NIBIB are developing a nucleic acid-based microsensor would permit point-of-care diagnosis and immediate treatment of urinary tract infections. This technology will enable physicians to determine, over a period of only ten to fifteen minutes, the bacterial pathogens present in a urine sample. Using this technology, a physician will be able to prescribe appropriate antibiotic therapy before the patient leaves his/her office.

National Institute on Alcohol Abuse and Alcoholism

As the proportion of adults over age 65 grows, the risk in this group for alcohol-related problems associated with normative lifestyle changes, declining health and functional status, and increased use of prescription and over-the-counter medications may increase. In addition, older persons differ biologically, psychologically and socially from younger people which may place them at especial risk for certain alcohol-related problems. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) program on aging includes epidemiologic research, prevention research and studies in the basic sciences, as well as outreach to older persons.

Outreach to Older Persons on National Alcohol Screening Day (NASD)
NIAAA staff wrote an article about Alcohol Screening Day for publication in the American Association of Retired Persons (AARP) regional newsletters in FY 2002, and provided an interview for an AARP sponsored radio broadcast in FY 2002. The American Association for Geriatric Psychiatry was a co-sponsor for NASD and the American Geriatrics Society were co-sponsors for NASD

Epidemiology of Alcohol Consumption among Older Americans
Older persons differ from younger persons in levels and patterns of alcohol consumption and in the risk and protective factors for and the consequences of that consumption. In 2002, NIAAA issued a program announcement entitled "Epidemiology of Alcohol Consumption and Alcohol-Related Problems in Older Persons" inviting applications to: (1) study patterns of alcohol consumption and the distribution of alcohol-related problems in the older and elderly population as a whole and in specific sub-populations of older persons; (2) study risk and protective factors for alcohol-related problems in the older persons (3) elucidate disparities among racial/ethnic groups of older and elderly persons with respect to alcohol consumption and alcohol-related problems; (4) understand the natural history, course, and short- and long-term outcomes of alcohol consumption among older and elderly persons.

In 2002, NIAAA staff studied alcohol consumption by older persons using existing nationally representative data. They found that approximately one-third of the US elderly population (aged 65+) consumed alcohol in the years 2000-2001 and that in increasingly older groups of men, moderate drinking remained stable and heavier drinking decreased, while for increasingly older groups of women, moderate drinking decreased and heavier drinking remained stable.

National Institute on Drug Abuse

Recognizing that prescription drug abuse in elderly populations is a growing problem, NIDA has taken steps to expand its research program in this area. NIDA issued a Program Announcement on Prescription Drug Abuse (PA-01-046), which focuses in part on elderly populations. In addition, in the last year NIDA established an internal workgroup, which includes representation throughout the Institute to determine how NIDA should best support and encourage research addressing the questions of how a history of drug abuse might affect the aging process, and whether drug abuse will emerge as a significant problem in the aging baby-boomer generation. The workgroup has and will continue to collaborate with other NIH Institutes (NIMH, NIA, NIAAA) in this endeavor.

NIDA currently funds one study entitled "Pain Medication Use & Risk Factors for Opioid Dependence" that is examining prescription opioid use in a community-based cohort of over 250,000 Medicare patients receiving prescription benefits through the Pennsylvania Pharmaceutical Contract for the Elderly program. This population is over 65, has limited income, is 81% female, and 92% white. The study will examine subjects taking prescription opioids chronically for rheumatoid arthritis and osteoarthritis pain and will determine patient and physician factors associated with potentially problematic opioid use. It will also examine

complications associated with chronic opioid use (e.g., fall-related fractures). While opioids are frequently prescribed in those over 65, there is little data on the extent to which this may lead to opioid abuse and dependence. This study will contribute significantly to our knowledge of prescription opioid use and abuse in the elderly.

Fogarty International Center

The Fogarty International Center of the NIH promotes and supports scientific research and training internationally to reduce disparities in global health. Developed nations have relatively high proportions of people aged 65 and over, but the most rapid increases in elderly populations are in the developing world. The current aggregate growth rate of the elderly population, in developing countries, is more than double that in developed countries and is also double that of the total world population. This increase in life expectancy is further complicated by the growing burden of chronic disease in aging populations in the developing world; including neurological, psychiatric, and developmental disorders. Research and training related to aging in the developing world not only aims not only to address these rapidly growing needs but also provides opportunities from diverse populations to develop basic and clinical scientific advances that provide lessons of value to the needs of Americans.

In recognition of the needs and opportunities posed by the demographic transition to an aging population in the developing world FIC has funded several research and training programs in FY 2000 and 2001 that strive to produce such results.

International Clinical, Operational and Health Services Research Training Award Program (ICOHRTA)

The ICOHRTA is an innovative program to support integrated multidisciplinary, clinical, operational, and health services research and training collaborations between U.S. institutions and those in developing countries, as well as between U.S. institutions and those in emerging democracies of Eastern Europe, Russia, and the Newly Independent States of the former Soviet Union. The program is intended to build much-needed capacity in low- and middle-income countries to translate research advances into care and treatment in many non-communicable disease areas including aging. The ICOHRTA provides opportunities for health professionals to train at the Ph.D., masters, and post-doctoral levels while working on international clinical and health services research projects.

Brain Disorders in the Developing World: Research Across the Lifespan

This new program grew out of the recognition of the enormous global burden of disease posed by neurological disorders across the lifespan. Cognitive disorders, neurodegenerative diseases and stroke are a few of the aging relevant research areas represented. This program supports research on these disorders and efforts to develop new interventions that will benefit low-income populations around the world, and particularly in developing countries. Research, research capacity building and training are all integral to the program.

International Studies on Health and Economic Development (ISHED)

This innovative new program is supporting studies aimed at elucidating the complex relationship between health and economic growth in low- and middle-income nations. Although it is widely

accepted that better education can lead to improved economic performance, the relationship between better health and the alleviation of poverty has not been fully explored in low- and middle-income countries. The first grants awarded through the ISHED competition are designed to determine the extent to which population health status and mental health status serve as predictive indicators of economic performance using a wide range of research methodologies and testable hypotheses.

International Training and Research Program In Population and Health

The Fogarty International Center (FIC), in collaboration with other Institutes and Centers of the NIH, has developed this program to support international research and training in population-related sciences. The intent of this program is to enable US scientists extend the geographic base of research and training efforts to developing nations, in support of international population priorities. The current demographic transition of the developing world toward an older population has broadened the needs of the research community to address not only traditional public health priorities, such as the study of reproductive processes and contraceptive development; but also the effects of changing age structure on communities undergoing stress related to both chronic and communicable diseases.

OFFICE OF INSPECTOR GENERAL

INTRODUCTION

The Office of Inspector General (OIG) for HHS, like numerous other Federal Inspectors General, is governed by the Inspector General Act of 1978, 5 U.S.C. App 3 (although the Inspector General for HHS was created by statute in 1978, Pub. L. 94-505, and was folded into the "umbrella" IG Act in 1988). The OIG's mission is to identify ways to improve effectiveness and promote economy and efficiency in HHS programs and operations, and protect them against fraud, waste, and abuse. This is accomplished by conducting independent and objective audits, evaluations, and investigations which provide timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public. In carrying out its mission, the OIG partners with the Department and its operating divisions, the Department of Justice (DOJ), other Federal and State agencies, and the Congress to bring about systemic improvements in HHS programs and operations, and successful prosecutions and recovery of funds from those who defraud the Government. The OIG is comprised of the following components:

The Office of Audit Services (OAS) conducts and oversees audits of HHS programs, operations, grantees, and contractors; identifies systemic weaknesses that give rise to opportunities for fraud, and abuse; and makes recommendations to prevent their recurrence. The OAS also provides overall leadership and direction in carrying out the responsibilities mandated under the Chief Financial Officers Act of 1990 and the Government Management Reform Act of 1994 relating to financial statement audits.

The Office of Evaluation and Inspections (OEI) seeks to improve the effectiveness and efficiency of departmental programs by conducting program inspections that provide timely, useful, and reliable information and advice to decision makers. These inspections are program and management evaluations that focus on specific issues of concern to the Department, the Congress, and the public. The results of these inspections generate accurate and up-to-date information on how well HHS programs are operating and offer specific recommendations to improve their overall efficiency and effectiveness.

The OIG's Office of Investigations (OI) conducts criminal, civil and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries. Investigative efforts lead to criminal convictions, civil judgements and settlements, administrative sanctions, and/or civil monetary penalties. OI serves as liaison to the Department of Justice on all matters relating to investigations of HHS programs and personnel. OI also oversees State Medicaid Fraud Control Units that investigate and prosecute fraud and patient abuse in the Medicaid program.

The Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the resolution of health care fraud and abuse cases, including the litigation and imposition of administrative sanctions, such as program exclusions, civil monetary penalties, and assessments;

the global settlement of cases arising under the Civil False Claims Act. The OCIG also provides all administrative litigation services required by OIG, such as in patient dumping cases and all administrative exclusion cases. It also develops and monitors corporate integrity agreements for providers that have settled their False Claims Act liability with the Federal Government. The OCIG develops and promotes industry awareness of models for corporate integrity and compliance programs and issues special fraud alerts and advisory opinions regarding the application of OIG's sanction statutes. It is also responsible for developing new, and modifying existing, safe harbor regulations under the anti-kickback statute. Finally, OCIG counsels OIG components on personnel and operations issues, subpoenas, audit and investigative issues, and other legal authorities.

The Office of Management and Policy (OMP) provides support services to the OIG, including congressional relations; public affairs; strategic planning and budgeting; financial and information resources management; and preparation of the OIG's semiannual and other reports.

ACCOMPLISHMENTS

During Fiscal Years 2001 and 2002, the OIG reported more than $2.4 billion in fines and restitutions deposited into the Medicare Trust Fund. More than 7,200 individuals and entities were excluded from doing business with Medicare, Medicaid, and other Federal and State health care programs. The OIG's 2001 and 2002 accomplishments included 940 convictions of individuals or entities that engaged in crimes against departmental programs.

The OIG reported savings of $39 billion for Fiscal Years 2001 and 2002. This is comprised of $36 billion in implemented legislative or regulatory recommendations and actions to put funds to better use; $837 million in audit disallowances, and close to $3 billion in investigative receivables. The savings that result from OIG recommendations that are implemented into law or regulation represent the dollars that will not be spent.

HEALTH CARE

In recent years, Medicare has been a major focus of OIG work. Approximately 80 percent of OIG resources in the past two years were dedicated to Medicare and Medicaid audits, evaluations, and enforcement activities. OIG work continues to show that Medicare is not always a prudent purchaser of health care goods and services and is inherently vulnerable to making improper payments. In discharging its responsibilities, the OIG responds both reactively and proactively to counteract these problems and reported that progress is being made. For example, through a statistically valid sample of FY 2002 Medicare fee-for-service payments, OIG estimated that the overall rate of claims paid in error was 6.3 percent or less than half the 13.8 percent reported for FY 1996.

A key element of HHS/OIG's prevention efforts has been the development of compliance

program guidance to encourage and assist the private health care industry to fight fraud and abuse. The guidance, developed in conjunction with the provider community, identifies steps that health providers may voluntarily take to improve adherence to Medicare and Medicaid rules. In 2002, the OIG published draft compliance program guidances for the pharmaceutical and ambulance industries and a notice soliciting comments regarding a revised hospital compliance program guidance.

Some of the significant OIG work involving the elderly, during this reporting period, includes the following:

Quality of Care in Nursing Homes. The OIG continued to focus on quality of care issues during the calendar year 2001/2002 reporting period, with reports on: resident assessment, beneficiary access to nursing facilities, the Senior Medicare Patrol Project, beneficiary complaints to the long term care ombudsmen, psychotropic drug use, nurse aide training, survey and certification deficiency trends, and the medical necessity of therapy services for nursing home residents.

In Fiscal Year 2001, the Government entered into a settlement agreement with Vencor, Inc., a major operator of nursing homes and long-term hospital services, following a joint OIG and Department of Justice investigation into allegations of billing abuses and poor quality of care. Vencor agreed to pay the Government a total of $219 million and to enter a comprehensive corporate integrity agreement requiring the company to implement a plan for improving the quality of care in its facilities.

In addition to the Vencor case and other successful quality of care investigations, OIG participated in a Nursing Home Steering Committee in Fiscal Year 2002. Headquartered in Washington, D.C., and comprised of representatives from OIG, DOJ, FBI and the Centers of Medicare and Medicaid Services, the Steering Committee has provided a forum for policy discussions on how these agencies can best use their individual and collective authorities to deter fraud, improve resident care, and coordinate Government action in nursing home bankruptcy and other financial and litigation matters.

The efforts of the Steering committee also contributed to the coordination and success of an OIG-sponsored event titled "Nursing Facility Quality of Care: Improving Government Enforcement Efforts." At this Washington, D.C. symposium, Federal and State prosecutors, investigators, and regulators exchanged ideas on how to improve Government's enforcement efforts through an analysis of the current methods used by the Government when pursuing failure of care cases.

Home Health. The OIG continued to assess access to home health services for beneficiaries, both those in the community and those needing services after hospital discharge. These studies confirmed that beneficiaries continued to have access to home health services. We also examined Medicare enrollment of home health agencies.

Medicare Program Oversight. The OIG examined CMS oversight of its contractors' operations, including duplicate claims paid by more than one carrier, inaccuracies in the unique physician identification number data files that are used to pay claims, carrier processing of claims with

invalid, inactive, and surrogate unique physician identification numbers, Medicare administrative appeals, and oversight of PPS-exempt hospital stays. These studies identified a number of potential improvements in Medicare operations that would reduce its vulnerability to fraud and abuse.

Drug Pricing. In response to climbing Medicare payments for certain drugs, the OIG examined pricing and Medicare reimbursement for albuterol, ipratromium bromide, anti-hemophilia drugs and selected Part B injections and infusible drugs. In each case, we found that Medicare could achieve substantial savings if it reimbursed at rates similar to those available to the Veteran's Administration, Medicaid programs (including rebates) or prices available to suppliers.

Medicaid Prescription Drugs. The OIG examined prescription drugs in the Medicaid program also, identifying both potential cost savings and program vulnerabilities. Studies included how Medicaid programs could save significant dollars in reimbursement to pharmacies for brand name and generic drugs, how they recover pharmacy payments from third party insurers and how Medicaid programs pay for HIV medications and mental health drugs.

ITEM 7—DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

1U.S. HOUSING PROGRAMS FOR THE ELDERLY—FISCAL YEAR 2001 AND 2002

The Department of Housing and Urban Development is committed to providing America's elderly with decent affordable housing appropriate to their needs. The Department's goal is to provide a variety of approaches so that older Americans are able to afford their housing costs, maintain their independence, remain as part of the community, and live their lives with dignity and grace.

This report provides a brief overview of the programs and activities undertaken by the Department to assist the elderly with their housing needs during fiscal year 2001and fiscal year 2002.

I. OFFICE OF HOUSING

A. SECTION 202 CAPITAL ADVANCES FOR SUPPORTIVE HOUSING FOR THE ELDERLY AND SECTION 811 SUPPORTIVE HOUSING FOR PERSONS WITH DISABILITIES

The National Affordable Housing Act of 1990 authorized a restructured Section 202 program while separating out and creating the new Section 811 program for Housing for Persons with Disabilities. Funding for both programs is provided by a combination of interest-free capital advances and project rental assistance. Project rental assistance replaces Section 8 rent subsidies. The annual project rental assistance contract amount is based on the cost of operating the project. The 30 percent maximum tenant contribution remains unchanged. Eligible owners of Section 202 projects are private nonprofit corporations with tax exemption under IRS Codes 501(c)(3) or 501(c)(4) and for Section 811 projects, eligible owners are nonprofit organizations with tax exemptions under IRS Code 501(3) only. The American Homeownership and Economic Opportunity Act of 2002 amended the Section 202 and 811 programs to expand project owner eligibility to include a for-profit limited partnership with a nonprofit entity as the sole general partner if, and only if, the proposed project will be a mixed-finance project for additional units over and above the Section 202 or Section 811 units, as applicable.

Since the passage of the National Affordable Housing Act of 1990, there have been 85,150 units approved under the Section 202 program and 22,573 units approved under the Section 811 program. Of those amounts 6,041 Section 202 units and 1,570 Section 811 were approved in fiscal year 2001. In fiscal year 2002, there were 6,830 additional units approved under Section 202 for

$585,170,100 and 1,859 more units approved under Section 811 for $148,008,100.

B. SECTION 221(D)(3) AND (4)—MORTGAGE INSURANCE PROGRAM FOR MULTIFAMILY HOUSING

Sections 221(d)(3) and (4) authorized the Department to provide insurance to finance the construction or substantial rehabilitation of market rate rental or cooperative projects. The programs are available to non-profit and profit-motivated mortgagors as alternatives to the Section 231 program. While most projects under the programs have been developed for families with children, projects insured under Section 221 may be designed for occupancy wholly or partially for the elderly, and the mobility impaired of any age. The Department does not have the actual statistics on the number of projects that have been designated for the elderly. The Section 221(d)(4) program is a very active and popular program and the number of projects designated for the elderly is quite small.

C. SECTION 232-MORTGAGE INSURANCE FOR NURSING HOMES, INTERMEDIATE CARE FACILITIES, BOARD AND CARE HOMES, AND ASSISTED LIVING FACILITIES

The Section 232 program authorized the Department to offer financing for the construction and rehabilitation (or purchase or refinance of existing projects) of nursing homes, intermediate care facilities, board and care homes, and assisted living facilities by providing mortgage insurance to finance these facilities. The vast majority of the residents of such facilities are the frail elderly. In fiscal year 2001, HUD insured 194 projects worth $1.3 billion (133 nursing homes, 54 assisted living facilities, and 7 board and care homes). In fiscal year 2002, HUD insured 309 projects worth $1.8 billion (214 nursing homes, 85 assisted living facilities, and 10 board and care homes).

D. SECTION 8 NEW CONSTRUCTION

The Section 8 program sponsored the new construction of housing for families and for the elderly by attaching subsidies to the units being developed. That way the landlord was guaranteed a stream of income that would facilitate finding financing and that would guarantee the ability to make payments and operate the developments. The new construction program was active from 1974 until it was repealed by Congress in 1983. No new units have been approved since 1983 but units approved prior to that may still receive a subsidy. The maximum term of the housing assistance payments vary from 20 to 40 years, depending on how the project was financed. There are 1.4 million private, project-based Section 8 units, about 50 percent of which serve elderly households. About 193,000 of these 658,000 units were built under the Section 202 program before the restructuring of that program in 1990. That means that about 465,000 units developed with Section 8 project-based assistance serve elderly households. The Section 8 new construction program is no longer used to subsidize new development.

E. SERVICE COORDINATORS IN ASSISTED HOUSING

The National Affordable Housing Act authorized funding for service coordinators under the Section 202 program in 1990. Eligibility was expanded to cover Sections 8, 221(d)(3) Below-Market Interest Rate (BMIR), and 236 projects in 1992. A service coordinator is a social service staff person who is part of the project's management team. The service coordinator is responsible for ensuring that the elderly individuals and persons with disabilities living in the project are linked with the supportive services they need from agencies in the community to assure that they can remain independently in their homes as long as possible and avoid premature and unnecessary institutionalization.

In fiscal year 2001, HUD awarded 217 grants worth $25,786,952. These grants serve 242 projects with a total of 22,083 units. Of the 242 projects, 148 are Section 202, 45 are Section 8, and 26 are Section 236/221(d)(3).

In fiscal year 2002, HUD made 223 grants for $30,374,307. These grants serve 242 projects with a total of 25.012 units. Of the 242 projects, 163 are Section 202, 28 are Section 221(d)(3) or 236s, and 51 are Section 8.

In fiscal year 2001 and 2002, HUD also provided 1-year extension funds to expiring Service Coordinator contracts. These extensions enable the Service Coordinator programs to continue operating without breaks. In fiscal year 2001, HUD made extensions to 314 contracts at a cost of $9,708,610. In fiscal year 2002, the Department extended 512 contracts with $15,831,440.

Funding for service coordinators in public housing is discussed below.

F. THE CONGREGATE HOUSING SERVICES PROGRAM

The Congregate Housing Services Program (CHSP), initially authorized in 1978 and revised in 1990, provides direct grants to States, Indian tribes, units of general local government and local non-profit housing sponsors to provide case management, meals, personal assistance, housekeeping, and other appropriate supportive services to frail elderly and non-elderly disabled residents of HUD public and assisted housing, and for the residents of Section 515/8 projects under the Department of Agriculture's Rural Housing and Community Development Service.

In fiscal year 2001, HUD extended 63 existing grantees for an additional year at a cost of $5,215,482. In fiscal year 2002, HUD extended 87 existing grantees for an additional year at a cost of $8,504,677. There were no funds appropriated for new grants in fiscal year 2001 or fiscal year 2002.

G. FLEXIBLE SUBSIDY AND LOAN MANAGEMENT SET ASIDE (LMSA) FUNDING

The Flexible Subsidy Program (FLEX) is comprised of two components: (1) the Operating Assistance Program (OAP), which is designed to provide temporary funding to replenish project reserves, cover operating costs, and pay for limited physical improvements. The Operating Assistance (OA) is provided in the form of a non-amortizing "contingent" loan; and (2) the Capital Improvement

Loan Program (CILP) is intended to assist projects with the cost of major capital improvements when funding such improvements cannot be done with project reserves. CILP assistance is provided in the form of an amortizing loan. Both programs are designed to restore or maintain the physical and financial soundness of eligible projects at the lowest possible cost to the Federal Government. Because of the limited funding, however, Flexible Subsidy funds are strictly reserved for the emergency needs of 202 projects. Such projects must have been in occupancy for at least 15 years and have emergency health and safety needs. No breakdown is available for fiscal year 2001 and fiscal year 2002.

The Loan Management Set Aside (LMSA) Program provides Project-based Section 8 funding to HUD-insured and HUD-held projects and projects funded under the 202 program which need additional financial assistance to preserve the long term fiscal health of the project. Funding has not been available for this program for several years.

H. MANUFACTURED HOME PARKS

The Housing and Urban-Rural Recovery Act (HURRA) of 1983 amended Section 207 of the National Housing Act to permit mortgage insurance for manufactured home parks exclusively for the elderly. The program has been operational since the March 1984 publication of a final rule implementing the legislation, although HUD insures very few manufactured home parks.

I. TITLE I PROPERTY IMPROVEMENT LOAN INSURANCE

Title I of the National Housing Act authorizes HUD to insure lenders against loss on property improvement loans made from their own funds to creditworthy borrowers. The loan proceeds are to be used to make alterations and repairs that substantially protect or improve the basic livability or utility of the property. There are no age or income requirements to qualify for a Title I loan. No breakdown is available for fiscal year 2001 and fiscal year 2002

J. TITLE I MANUFACTURED HOME LOAN INSURANCE

Title I of the National Housing Act authorizes HUD to insure lenders against loss on manufactured home loans made from their own funds to creditworthy borrowers. The loan proceeds may be used to purchase or refinance a manufactured home, a developed lot on which to place a manufactured home, or a manufactured home and lot in combination. The home must be used as the principal residence of the borrower. There are no age or income requirements to qualify for a Title I loan. No breakdown is available for fiscal year 2001 and fiscal year 2002.

K. HOME EQUITY CONVERSION MORTGAGE INSURANCE PROGRAM

The Department has implemented a program to insure Home Equity Conversion Mortgages (HECM), commonly known as "reverse mortgages." The program is designed to enable persons aged 62 years or older to convert the equity in their homes to monthly streams of income and/or lines of credit. No breakdown is available for fiscal year 2001 and fiscal year 2002.

L. SECTION 231—MORTGAGE INSURANCE FOR HOUSING FOR THE ELDERLY

Section 231 of the National Housing Act authorized HUD to insure lenders against losses on mortgages used for construction or rehabilitation of market rate rental accommodations for persons aged 62 years or older, married or single. Nonprofit as well as profit-motivated sponsors are eligible under this program. The program is largely inactive and produced no units in fiscal year 2001 or fiscal year 2002.

II. OFFICE OF PUBLIC AND INDIAN HOUSING

A. HOUSING CHOICE VOUCHER PROGRAM

Section 8 of the U.S. Housing Act of 1937 authorizes housing assistance payments to aid low-income families in renting decent, safe, and sanitary housing that is available in the existing housing market under the Housing Choice Voucher program.

The Housing Choice Voucher program is HUD's largest assisted housing program. About 16 percent of the 1.8 million voucher program households, or 288,000, are headed by elderly persons.

B. ELDERLY/DISABLED SERVICE COORDINATORS

Section 673 of the Housing and Community Development Act of 1992 authorized the Department to fund service coordinators in public housing developments to ensure that the elderly and non-elderly disabled residents have access to the services they need to live independently. From fiscal year 1994 to 1998, the Department awarded 227 grants totaling approximately $62.8 million for public housing authorities to hire service coordinators for their elderly and non-elderly disabled residents to provide general case management and referral services, connect residents with the appropriate services providers, and educate residents on service availability. Service coordinator grants that were previously awarded are being renewed annually to maintain the level of services for elderly residents and residents with disabilities.

C. TENANT OPPORTUNITY PROGRAM

Section 20 of the U.S. Housing Act of 1937, as amended, authorized the Tenant Opportunities Program (TOP). The program enables resident entities to establish priorities and training programs for their specific public housing communities that are designed to encourage economic development, stability, and independence. The program began in 1988 and to date has awarded about 986 grants totaling approximately $80 million. Public housing developments with elderly residents are eligible to participate and perhaps 7 percent are primarily elderly grantees.

As part of the implementation of Section 538 of the Public Housing Reform Act, the TOP program was consolidated into the Resident Opportunities and Self Sufficiency (ROSS) program. Section 538 authorizes a program to link services for public housing residents to promote self-sufficiency and economic empowerment. Many of the activities previously eligible under TOP are eligible under ROSS.

D. PUBLIC HOUSING DEVELOPMENT PROGRAM

The Public Housing Development Program was authorized by Sections 5 and 23 of the U.S. Housing Act of 1937 to provide adequate shelter in a decent environment for families that cannot afford such housing in the private market. In 1998, the Quality Housing and Work Responsibility Act authorized the Capital Fund. A Public Housing Agency choosing to develop new public housing can do so using its annual formula grant of Capital Funds. Public housing elderly units may also be developed under the HOPE VI Program.

In fiscal year 2001, 40 elderly units started construction and 320 became available for occupancy. In fiscal year 2002, 116 elderly units because available for occupancy. Under the HOPE VI program, 123 units became available in fiscal year 2001 and 72 became available in fiscal year 2002. (The elderly units only reflect the HOPE VI grants dedicated to elderly redevelopment. While there may be other elderly units produced under HOPE VI, HUD's current data system does not distinguish between units occupied by the elderly and families.)

III. OFFICE OF COMMUNITY PLANNING AND DEVELOPMENT

A. COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) ENTITLEMENT COMMUNITIES PROGRAM

The CDBG Entitlement Communities program is HUD's major source of funding to large cities and urban counties for a wide range of community development activities. These activities primarily help low- and moderate-income persons and households; however, they can also be used to help eliminate slums and blight or meet other urgent community development needs.

The Department normally does not ask grantees to report CDBG program beneficiaries by age. However, in reporting on their use of CDBG funds, two activity classifications do reflect funds used specially for activities that serve senior citizens: senior services and senior centers. The former are eligible as public services, and the information reported by all grantees shows that in both Federal Fiscal Year 2001 and 2002, slightly more than 1 percent of the CDBG funds disbursed were used for public services targeted to senior citizens (about $41 million each year). Another 0.8 percent (about $27 million) in 2001 and 0.9 percent (about $32 million) in 2002 were spent for public facilities that were specifically identified as senior centers. In addition, senior citizens frequently benefit from local housing rehabilitation programs that are funded by CDBG, but when reporting on rehabilitation activities, there is no separate category that reflects the number of citizens that benefit from CDBG-assisted housing rehabilitation programs.

B. CDBG STATE-ADMINISTERED AND HUD-ADMINISTERED SMALL CITIES PROGRAMS

The CDBG State-administered program (and its predecessor, the HUD-administered Small Cities program, which still operates in Hawaii) is HUD's principal vehicle for assisting communities with

populations under 50,000 that are not central cities of metropolitan areas. States provide grants to small cities, counties and other units of local government, which use the CDBG funds to undertake a broad range of activities. (HUD makes grants directly to counties in Hawaii.) As is also true with the Entitlement Communities program, these activities must primarily help low- and moderate-income persons and households though they can also be used to help eliminate slums and blight or meet other urgent community development needs.

For most CDBG-funded projects, the Department does not require grantees to report program beneficiaries by age. However, there are two categories of eligibility in the CDBG Program that are senior-oriented: senior centers and senior services. Between 2001 and 2002, CDBG State-administered program grantees doubled the amount of CDBG program funds spent on senior centers, from 0.79 percent of total spending in 2001 ($9,615,604) to 1.43 percent of total spending in 2002 ($18,039,132). In that same time period, spending on public services targeted to seniors remained steady at 0.06 percent of total spending, from $668,642 in 2001 to $695,043 in 2002.

In addition, HUD is aware of many other categories of eligibility within the CDBG program that directly benefit senior citizens, but for which grantees do not have to report age. Rehabilitation of single-unit residential housing, in particular, is a category of eligibility that often provides benefit to senior citizens. The true extent of benefit to the elderly in the State CDBG program is very likely high, since many small communities and rural areas have high concentrations of elderly persons.

C. HOME INVESTMENT PARTNERSHIPS (HOME) PROGRAM

The HOME Program continues to serve as a major resource for elderly housing assistance, particularly for the rehabilitation of deteriorating properties of low-income elderly homeowners, allowing them to remain in their own homes and keep those homes in standard condition. The figures below represent the number of HOME-assisted units that participating jurisdictions reported were completed and occupied by elderly residents during fiscal year 2001 and 2002 and the percentage of units in the category that these figures represent:

Tenure Type	Fiscal Year 2001–2002	Elderly Cumulative	Total Units Completed	Percentage Elderly
Homeowner Rehabilitation	8,634	42,579	101,160	42%
Rental Units	11,118	31,264	150,661	21%
New Homebuyers	1,260	4,970	180,807	3%
TOTAL Elderly Units	21,012	78,813	432,628	18%

To date, HOME has assisted 78,813 low-income elderly households. This constitutes an investment of over $1,962,453,000 in HOME funds, which have leveraged another $6,768,128,000 in private investment and other non-HOME funds (which includes Federal, State and local funds) to provide housing for the elderly (estimates based on a weighted average of $24,900/per unit HOME subsidy for production, and conservative estimate of $3.45 per $1.00 of HOME as leverage).

For data collection purposes, the HOME Program defines elderly as 62 or older. Therefore the above numbers do not reflect projects which are designed for seniors between 55 and 62.

D. EMERGENCY SHELTER GRANTS PROGRAM

The Emergency Shelter Grants (ESG) Program provides funds to States, metropolitan cities, urban counties, Indian tribes, and territories to improve the quality of emergency shelters, make available additional shelters, meet the cost of operating shelters, provide essential social services to homeless individuals, and help prevent homelessness.

According to a 1999 Federal study entitled *HOMELESSNESS: Programs and the People They Serve*, about 2 percent of homeless persons are 65 years or older. Approximately 1 percent of the ESG funds go to seniors-only facilities for the homeless. However, the elderly homeless population often receives emergency housing and services at various shelter facilities that serve a range of age groups, although often targeted to a particular sex or family status.

E. SUPPORTIVE HOUSING PROGRAM

The Supportive Housing Program (SHP) funds may be used to provide: (1) transitional housing designed to enable homeless persons and families to move to permanent housing within a 24 month period, which may include up to 6 months of follow-up services after residents move to permanent housing; (2) permanent housing provided in conjunction with appropriate supportive services designed to maximize the ability of persons with disabilities to live as independently as possible within permanent housing; (3) safe havens supportive housing for hard to reach homeless persons with severe mental illness, who are living on the streets and are unwilling or unable to participate in services; (4) innovative supportive housing; or (5) supportive services for homeless persons not provided in conjunction with supportive housing.

IV. OFFICE OF FAIR HOUSING AND EQUAL OPPORTUNITY

A. THE FAIR HOUSING ACT

The Fair Housing Act prohibits discrimination in housing based on race, color, religion, sex, national origin, handicap, or familial status. The Act exempts from its provisions against discrimination based on familial status "housing for older persons." The statutory exemption of "housing for older persons" comprises three categories of housing: (1) housing provided under any State or Federal program that the Secretary of HUD determines is specifically designated and operated to assist elderly persons; (2) housing intended for and solely occupied by residents 62 years of age and older; and (3) housing intended and operated for occupancy by at least one person 55 years of age or older per unit, provided various other criteria are met.

B. THE HOUSING FOR OLDER PERSONS ACT OF 1995

The Housing for Older Persons Act (HOPA) of 1995 amends the "55 and older" housing exemption to the Fair Housing Act's prohi-

bition against discrimination based on familial status. HOPA eliminates the requirement that housing "55 and older" have significant facilities and services and establishes a good faith reliance defense from monetary damages for individual real estate professionals on a legitimate belief that the housing was entitled to an exemption. In order to qualify for the "55 and older housing" exemption a housing community or facility must: (1) have at least 80 percent of its occupied units occupied by at least one person 55 years of age or older; (2) publish and adhere to policies and procedures which demonstrate an intent by the owner or manager to provide housing for persons 55 and older; and (3) comply with the rules issued by the Secretary for verification of occupancy through reliable surveys and affidavits.

C. AGE DISCRIMINATION ACT

The Age of Discrimination Act of 1975 prohibits programs or activities receiving Federal financial assistance from directly or through contractual, licensing, or other arrangements, using age distinctions or taking any other actions which have the effect, on the basis of age, of: excluding individuals from, denying them the benefits of, or subjecting them to discrimination under a program or activity receiving Federal financial assistance; or denying or limiting individuals their opportunity to participate in any program or activity receiving Federal financial assistance. The Department's regulations implementing the Age Discrimination Act became effective on April 10, 1987, and are codified at 24 CFR Part 146.

No breakdown is available for fiscal year 2001 or fiscal year 2002 on the number of complaints received or mediated.

D. DESIGNATED HOUSING

The 1992 Housing and Community Development Act authorized HUD to approve Public Housing Authority plans to designate mixed population housing units (serving elderly and persons with disabilities) for elderly families only, disabled families only, or elderly and disabled families, if the plans met certain statutory requirements outlined in Section 7 of the United States Housing Act. The Housing Opportunities Program Extension Act of 1996 simplified and streamlined those requirements, but continued to require HUD to review and approve or disapprove designated housing plans.

No breakdown is available for fiscal year 2001 or fiscal year 2002 on the number of units designated for elderly families.

V. OFFICE OF POLICY DEVELOPMENT AND RESEARCH

A. AMERICAN HOUSING SURVEY

The American Housing Survey for the United States, Current Housing Report Series Number H150 for the year 2001 contains special tabulations on the housing situations of elderly households in the United States. Chapter 7 of the regular report provides detailed demographic and economic characteristics of elderly households, detailed physical and quality characteristics of their housing units and neighborhoods and the previous housing of recent movers, and their opinions about their house and neighborhood. The

data are displayed for the four census regions, and for central cities, suburbs, and non-metropolitan areas, and by urban and rural classification. The non-elderly chapters (total occupied, owner, renter, Black, Hispanic, central cities, suburbs, and outside MSAs) also contain data on the elderly. In addition, Current Housing Report Series Number H170 contains data on the elderly for the 47 largest metropolitan areas that are individually surveyed over four- to 6-year cycles. These reports are available in hardcopy versions for purchase or in electronic formats for downloading from the Internet. An elderly household is defined as one where the householder, who may live alone or head a larger household, is aged 65 years or more. Special information in these publications is provided on households in physically inadequate housing or with excessive cost burden, and on households in poverty.

B. STUDY OF PROJECT SIZE IN SECTION 811 AND SECTION 202 ASSISTED PROJECTS FOR PERSONS WITH DISABILITIES

Since the 1970's, there have been increasing efforts to reduce the number of persons with disabilities who live in institutional settings. Early on, the housing provided to people with disabilities-through HUD's Section 202 program-tended to be in large congregate settings. These congregate facilities, containing anywhere from 30 to 120 units, offered a package of supportive services; residents were frequently required to use these services as a condition of tenancy.

While congregate developments offer a less restrictive setting than hospitals or nursing homes, advocates for people with disabilities have argued that these facilities continued to segregate disabled people from their communities and that persons with disabilities would be better served in small settings that housed fewer than five people. Some advocates have further contended that housing and services should not be linked, and that receiving supportive services should not be a condition of tenancy.

HUD's Section 811 program was developed to provide additional affordable housing options for persons with disabilities, particularly in small group homes and independent living facilities. The majority of the almost 1,600 projects that have been built since 1991 (65 percent) contain between 8 and 24 units. Most of the remaining projects (32 percent) have fewer than 8 units. HUD has further expanded housing options by designating more than 60,000 vouchers for people with disabilities since 1994.

While persons with disabilities have many more housing options today than they did thirty years ago, there continues to be a serious lack of affordable housing for persons with disabilities and many low income people with disabilities face severe rent burdens. In addition, there has been an ongoing debate over the appropriate size of projects for people with disabilities. On one hand, advocates contend that persons with disabilities prefer and are more independent living in small developments that blend in with the surrounding neighborhoods. On the other hand, it has been argued that larger projects are less expensive to build and operate, an issue that must be carefully weighed given the significant need for affordable housing for this population.

The objective of this study is to investigate the social and economic impact of project size on Section 811 and 202 projects, their residents, and the immediate neighborhoods. In addition, a congressional mandate requires that this study look specifically at:

- The benefits and problems associated with providing Section 811 housing in projects that have 8 or fewer units, 9 to 24 units, and more than 24 units; and
- The benefits and problems associated with providing housing for non-elderly persons with disabilities under Section 202, in projects having 30 to 50 units, 51 to 80 units, 81 to 120 units, and more than 120 units.

C. "WHAT DO WE KNOW ABOUT HOW TO CREATE AFFORDABLE ASSISTED

LIVING?" Internal Report, Interagency Agreement Between the Office of the Assistant Secretary for Planning and Evaluation (U.S. Department of Health and Human Services) and the Office Of Policy Development and Research (U.S. Department Of Housing and Urban Development) for Developing a Policy and Research Agenda on Affordable Residential Supports with Services/Affordable Assisted Living (Completed 2002)

Because the population of elderly persons who need long-term care (LTC) will grow dramatically over the next several decades, Federal and State policymakers need a better understanding of how to combine supportive housing with the provision of LTC services in a way that will be affordable for low-income seniors and help them to avoid institutionalization for as long as possible.

Individuals, their families, and increasingly, policymakers view assisted living as a potential alternative to nursing home care or as a means to forestall admission to a nursing home. In theory, assisted living is a desired alternative to traditional supportive housing with services—often called board and care or adult care homes—primarily because it offers privacy, autonomy, and, in many instances, a progressive level of services that allows people to stay in the same setting when their service needs increase; i.e., these settings are supposed to permit elderly persons to "age in place." However, market rate assisted living—which can range from $30,000 to $60,000 per year—is not affordable for many, if not the majority of elderly persons. Consequently, there is increasing interest among advocates for elderly persons and policymakers to determine how the market rate model of assisted living—a relatively new model of supportive housing with services—can be made affordable for low income persons.

The price of market rate assisted living is based on two components: housing and services. While 38 States now cover services in some type of assisted living setting through their Medicaid programs, Medicaid does not pay for room and board in these settings. In most States, eligibility for the Supplemental Security Income (SSI) program confers eligibility for Medicaid. However, since 1990 SSI benefit levels have not kept pace with rising housing costs. People receiving SSI benefits have incomes that average 18.5 percent of median income nationally, and so need a long-term rental subsidy such as Section 8 in order to afford housing. Given this, it can be assumed that any assisted living property developed for peo-

ple receiving Medicaid benefits will need a project based rent subsidy.

For those not eligible for SSI, there are complex Medicaid provisions and Federal options that can enable persons with higher incomes to be eligible for services and have income left to pay for housing. However, there is considerable variation among States in their adoption of these options. Consequently, there are many older adults with low incomes who are financially ineligible for Medicaid but cannot afford to pay privately to reside in residential alternatives to nursing homes that provide privacy, autonomy, as well as the range of services they need to avoid institutionalization.

Before deciding whether and what policy changes to make to increase the availability of assisted living for low-income elderly persons, more research and analysis may be required. To this end, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services (HHS), in partnership with the Office of Policy Development and Research (PD&R) at the Department of Housing and Urban Development (HUD), have contracted with RTI to recommend issues and areas that require research and/or policy analysis in order to inform policy regarding the public financing of assisted living.

Methods: To determine recommendations for future research and analysis, RTI identified and contacted 24 experts in Medicaid, home and community services, housing, and assisted living. These experts included academic researchers, policy analysts, a State policymaker, and those who represented provider and consumer views.

Because very few people are experts in both housing and service programs, a paper was prepared to provide background information in each area—housing and services. The housing section detailed the difficulties faced in using public programs to subsidize the housing component of assisted living to make it more affordable. The services section was focused more broadly on service issues generally, and issues related to the Medicaid program specifically. The paper also identified key program and policy issues when combining housing and services for low-income elderly persons, and described key Federal housing subsidy programs. The primary purpose of the paper was to raise issues and stimulate thinking about issues that require research and analysis.

D. ASSISTED LIVING CONVERSION PROGRAM (ALCP) EVALUATION

Currently, PD&R is conducting an evaluation concerning the population of elderly persons who need long-term care will grow dramatically over the next several decades. In anticipation of this demographic change, the Department is interested in better understanding how supportive housing, such as affordable assisted living, can help low-income, frail older person avoid institutionalization for as long as possible. This evaluation of the Assisted Living Conversion Program presents an opportunity to take an exploratory look at a new HUD program that provides affordable aging-in-place to frail, low-income seniors. The study shall document strategies of successful grantees, identify barriers to full utilization of the program, describe the level of satisfaction with residents of recently converted assisted living facilities, and assess future need that can be met by the program. The objective of the study is to

document how HUD's ALCP is working and to identify obstacles to the full utilization of the program.

ITEM 8—DEPARTMENT OF THE INTERIOR

REPORT ON DEVELOPMENTS IN AGING CALENDAR YEARS 2001 AND 2002

DEPARTMENTAL OFFICE FOR EQUAL OPPORTUNITY

The Departmental Office for Equal Opportunity (OEO) enforces various Federal anti-discrimination laws that prohibit discrimination on the basis of race, color, national origin, disability, sex and age in all aspects of the Department of the Interior's (DOI) operations. OEO is the focal point within DOI for ensuring compliance and enforcement of these laws including those addressing age discrimination. In calendar years 2001 and 2002, OEO promoted an array of proactive diversity initiatives to ensure nondiscrimination in DOI's employment practices, i.e., diversity and strategic planning presentations, civil rights and equal employment opportunity training, etc. During the 2001 and 2002 year period, DOI provided equal employment opportunity counseling services through highly trained collateral duty Equal Employment Counselors. DOI continues to demonstrate commitment to non-discrimination in the workplace by: a) ensuring that individuals are not denied employment or career advancement opportunities because of their age or any other non-merit factor; and b) ensuring "zero tolerance" for any form of discrimination including age discrimination.

Civil Rights Complaints.—The general public is apprised of how to file age discrimination complaints with DOI through a national public notification program. This public notification program requires recipients to prominently post DOI nondiscrimination posters in a reasonable number of places throughout all areas of their operations. As a part of this program, recipients are also required to proclaim DOI's nondiscrimination policy, which includes the procedures for filing age discrimination complaints, in all publications and other materials used by recipients to describe program availability.

During the period, DOI processed four age discrimination complaints against DOI recipients of Federal financial assistance. DOI's complaint processing procedures incorporate routine determinations as to whether a complaint is within DOI's jurisdiction and covered by the Age Discrimination Act of 1975. In 2001, DOI processed a total of 158 civil rights complaints of which two were age discrimination complaints. The complaints involved covered programs and activities of the U.S. Fish and Wildlife Service. Generally, the complaints did not relate to discriminatory age based policies, rather the focus was on problems of maltreatment and inaccessible programs encountered by "senior citizens." As a matter of policy, complaints that are received by DOI that contain suffi-

cient information which identify the recipient, the location of the program or activity, the policy or issue in question, and the approximate date the alleged discrimination occurred are routinely referred to the Federal Mediation and Conciliation Service (FMCS), as required by Departmental regulation. However, during 2001 and 2002, DOI did not refer any alleged age discrimination complaints to the FMCS.

In 2002, out of a total of 117 civil rights complaints received by DOI, as in 2001 only two complaints alleged discrimination on the basis of age. One complaint was processed by the National Park Service and the other was processed by the Bureau of Reclamation. Both complaints concerned particular age distinctions in public recreation programs. The age discrimination complaint handled by the National Park Service was closed through voluntary compliance and by way of an alternative dispute resolution process. The complaint concerned an elderly cyclist who found that she was competing against 25 year olds in an annual bicycle race. The complainant contended that this was unfair. In consideration of the complainant's concerns, the sponsors of the race voluntarily agreed to change the age ranges for future contests.

The complaint processed by the Bureau of Reclamation alleged that preferential camping permit policies in a State park and recreation program afforded senior citizens unfair preferential treatment based on age. In consultation, with the Department of Health and Human Services, DOI found in the instant case that the Age Discrimination Act did not apply to the recipient because its policies and practices were special benefits to the elderly that was presumed to be necessary to the normal operation of the program.

Compliance Reviews..—In 2001 and 202, compliance reviews of DOI's federally assisted programs were conducted in select program areas that covered age discrimination issues. These reviews were conducted to ascertain, in part, whether or not DOI's recipients of Federal financial assistance were in compliance with the requirements of the Age Discrimination Act. Three of DOI's bureaus have continuous civil rights compliance and enforcement programs that provide for conducting civil rights compliance reviews, complaints processing, training, and the provision of technical assistance in DOI's most service-delivery oriented Federal assistance programs. All DOI civil rights compliance reviews are accomplished in consideration of the requirements of the Age Discrimination Act.

In 2001, various DOI bureaus and offices conducted over 900 civil rights compliance reviews of both applicants and recipients of Federal financial assistance. All civil rights compliance reviews conducted by DOI's bureaus and offices are accomplished in consideration of the requirements of the Age Discrimination Act. Pre-award reviews are conducted of all approved applicants of Federal financial assistance. These reviews, as do post-award reviews, incorporate compliance review criteria for determining whether or not applicants and recipients are in compliance with the Act. As a routine course of action, DOI provides expert technical assistance to its recipients on the requirements of the Act, during complaint investigations and compliance reviews.

In 2002, DOI conducted a total of 72 civil rights compliance reviews of applicants and recipients of Federal financial assistance.

During the conduct of these reviews, recipient operations were reviewed to determine whether or not they were in compliance with the requirements of the Age Discrimination Act. Moreover, during these reviews technical assistance was provided to aid recipients in complying with the Act. To date, the DOI's most user-oriented types of Federal assistance programs are covered by a continuous civil rights compliance review program that gauge whether recipients are in compliance with the Act.

Civil Rights Assurances.—In 2001, DOI revised its *Departmental Civil Rights Assurance* form to include, among other nondiscrimination provisions, a specific provision barring age discrimination in any program or activity receiving federal financial assistance.

Regulatory Development.—In coordination with the Department of Justice, DOI reviewed its current Departmental Age Discrimination Regulation at 43 CFR 17, Subpart C, and identified areas of the regulation for proposed modification for conformance with the standards of the Civil Rights Restoration Act of 1987. As a result, DOI published a proposed rule in the *Federal Register* and signed off on a final rulemaking document. The final rulemaking document was forwarded to the Department of Justice for prepublication clearance. This regulatory activity was accomplished by DOI in light of the Third Circuit decision in *Cureton* v. *NCAA,* No. 99–1222, 198 F.ed 107. (1999).

Coverage.—In 2001, DOI broadened its civil rights compliance and enforcement program to cover federally assisted programs and activities of the U.S. Geological Survey (USGS). The USGS developed an internal compliance and enforcement program in its Equal Opportunity Office to ensure that all programs and activities receiving Federal financial assistance are in compliance with the Act and other similar Federal civil rights laws. One full-time staff member was committed to the USGS's Equal Opportunity Office of carrying out this responsibility. DOI continues to operate ongoing civil rights compliance and enforcement programs in its most costumer-oriented bureaus, i.e., the National Park Service, the U.S. Fish and Wildlife Service, the Office of Surface Mining, and the Bureau of Reclamation. Each bureau had established compliance and enforcement programs for ensuring continuous adherence to the requirements of the Act.

Training.—During the period, DOI's OEO provided several instances of Departmentwide civil rights training for bureaus and offices charged with ensuring civil rights compliance in federally assisted programs and activities for which they are responsible. Experts from the Department of Health and Human Services were relied upon in making these training activities successful. Civil rights training was provided to all DOI equal opportunity personnel who are generally responsible for the enforcement of civil rights laws in their respective bureaus and offices. The training covered DOI's various civil rights compliance and enforcement responsibilities in federally assisted programs and activities, including the application of the Act. More specifically, the training covered such matters as the conduct of compliance reviews, complaint investigations, recipient public notification requirements, and the provision of technical assistance.

Policy Guidance.—Policy guidance and procedural information were developed on the procedures for conducting complaint investigations. Comprehensive guidance was issued on DOI's civil rights public notification compliance requirements.

Office of Human Resources

Older Americans Month.—Each May, DOI commemorates Older Americans Month. In observance of the month, DOI concluded that " nearly one in four United States Households care for an older family member, and 64 percent of caregivers are employed." During this special month DOI hosted several elder care events for the benefit of its employees. In its employee cafeteria information and resources were disseminated and made available to employees and visitors on elder care issues such as health, Alzheimer's disease and housing. DOI's Employee Assistance Program conducted seminars on the process of aging, the psychological challenges present in that process, and information was made available regarding resources available to meet those challenges. The seminars addressed such topics as: (1) the various states of aging; (2) the processes for coping with stages of the aging process; (3) the affect of the aging process on individuals and families; and (4) resources and support systems available for coping with the aging process. DOI partnered with the Office of Personnel Management (OPM) in hosting "lunch and learn" discussions for both DOI and OPM employees on financial planning for one's "golden years." Additionally, in consideration of the balancing and stress that are associated with "work-life" experiences in caring for elderly persons, DOI hosted an open house Stress Laboratory to aid its employees in "developing the strength and stability to carry on on a myriad of responsibilities."

Minerals Management Service

The Minerals Management Service (MMS) continues to work to support programs for older Americans. The MMS work force statistics show that:

- Eighty-one percent of the MMS work force is comprised of employees who are 40 and over (1,114 of 1,719);
- Older employees are well represented in a variety of occupations within the MMS, including accountants, auditors, computer specialists, engineers, geologists, geophysicists, and physical scientists;
- The MMS has implemented and continues to implement effective personnel management policies to ensure that equal opportunity is provided to all employees and applicants, including older Americans.

The MMS continues to explore and implement initiatives to assist employees to care for elderly parents. Family support rooms have been established in our Herndon, Virginia, and Lakewood, Colorado offices. Rooms are available for employees to bring their elderly parents for short term care on an occasional basis, when necessary, in order to facilitate such events as ease in keeping medical appointments. Other family-friendly initiatives, such as leave share and the Family and Medical Leave Act, have been implemented and used to benefit workers who have older relatives

with medical situations. MMS supports the wellness of employees by subsidizing membership costs to health clubs. This is of great benefit to all employees, including older employees.

The MMS continues to perform its mission-related functions in an outstanding manner. A major mission responsibility affecting large numbers of citizens is the mineral royalty payments to various landholders, including numerous older Americans who often depend heavily on these payments to meet their basic human needs and rely on the ability of the MMS to effectively discharge its financial responsibilities.

The MMS offshore mission has the ultimate objective of managing domestic mineral production through offshore resources. Significant effects on the economic well-being of all Americans, including older Americans, occur if dependence on foreign mineral (e.g., oil and gas) imports is reduced.

OFFICE OF SURFACE MINING RECLAMATION AND ENFORCEMENT

The Office of Surface Mining Reclamation and Enforcement (OSM) is steadfast in its commitment to provide equal opportunity to all persons in all matters of employment. OSM has a policy statement, signed by the Director, explaining that discrimination based on age (40 or older) will not be tolerated. This policy statement is displayed throughout all of OSM. In addition, older employees are represented in most OSM's occupational series. Basically, 19 percent of OSM's current workforce is eligible to retire immediately and an additional 31.6 percent will be eligible to retire in the next 1–5 years.

OSM is always trying to keep abreast of what is important to its employees and to improve their quality of work life. During the past two years, OSM sponsored seminars, including FERS Retirement, Heart Disease, Diabetes, Tax, Stress Management, and a seminar entitled "Its Your Life, Live it". These seminars were chosen because of their direct and/or indirect impact on OSM's workforce.

Awards were given to many OSM employees for 25, 30, and 35 years of continuous service during calendar years 2001 and 2002.

BUREAU OF RECLAMATION

Human Resources.—The Bureau of Reclamation conducts many activities throughout the year that affect and benefit aged individuals. Personnel offices maintain contacts and provide services to many retirees who need advice or have questions concerning their retirement and health benefits. Retirees and their spouses attend annual health insurance fairs where insurance representatives are available to discuss the provisions of their health care plans. Several of Reclamation's regional offices continue to mail out a monthly newsletter to all retirees. The newsletter contain about Reclamation's former and current employees and are highly regarded by retirees as a way to keep in touch. Additionally, retirement planning briefings and seminars are held for all interested employees as a retirement planning benefit.

The Bureau of Reclamation established a Work and Family Team (WAFT) to advance a Presidential directive on Family-Friendly

Work Arrangements. Initiatives taken on behalf of older Americans and their families are principally addressed in this arena. The alternative work schedules in place throughout Reclamation allow employees to arrange their work schedules to address family needs. This is in addition to its telecommuting policy and support of the Family and Medical Leave Act of 1993.

Employment Opportunities.—Reclamation's Weber Basin Job Corps Civilian Conservation Center in Ogden, Utah, has an agreement with the Easter Seals in accordance with Title V of the Older Americans Community Service Employment Act of 1973. The agreement serves to foster meaningful part-time employment opportunities in community service activities for unemployed low-income persons who are 55 years of age or older. Weber Basin currently employs these individuals as motor vehicle operators, warehouse labors and clericals.

Reclamation's Collbran Job Corps Civilian Conservation Center in Collbran, Colorado continues to employ older Americans at the Center through a Senior Community Service Employment Program. Reclamation's Centennial Job Corps Civilian Conservation Center in Nampa, Idaho has an agreement with AARP, a nonprofit organization devoted to addressing the concerns of individuals who are 50 years of age and older. The agreement is intended to promote employment opportunities for older workers.

Accessibility.—Through a ten-year plan the Bureau of Reclamation that was in an implementation phrase in calendar years 2001 and 2002, Reclamation's facilities, programs, and services were made readily accessible to the elderly and persons with disabilities. These evaluations are still in progress. As of the end of the reporting period, 680 to 957 Reclamation facilities have been evaluated and consequently steps have been taken to remove all identified barriers.

During the period, progress towards full accessibility has resulted in modifications to Reclamation offices, visitor facilities, restrooms, campgrounds, administrative offices, boating facilities, and picnic areas to provide access to the elderly and people with disabilities. The modifications that have been accomplished include the provision of: (1) access ramps; (2) handrails; (3) improved walkways and trail gradients; (4) accessible restrooms; and (5) wider entrance ways. In addition, modifications to Reclamation programs have resulted in captioned videos, brochures with large print, audio description of videos and films, and the use of signage to identify sites and facilities.

These changes provide the elderly easier access to Reclamation's facilities and greatly improved information about the availability and location of Reclamation programs, activities, facilities, and services.

To date, Reclamation has evaluated 173 of 242 work sites to determine whether or not they are readily accessible to older employees and individuals with disabilities.

Great Plains Region.—The Region continues to consider the contributions of its older workers. Regional facilities have been made accessible. The following activities are representative of the results realized by the Great Plains Region during the period.

1. The Region employed a total of 346 employees over 50 years of age. Of those employees, 15 were 62 years or older. A breakdown by age group is illustrated below:

Age Group	Number of Employees
50–54 years	165
55–59 years	130
60–70 years	51

In addition, the Region employed two reemployed annuitants who are still employed as of calendar year 2003.

2. Recreational opportunities were enhanced at many reservoirs and recreational areas which have traditionally attracted many seniors citizens and retired individuals.

3. The core of Reclamation's volunteer program was based upon retirees and senior citizens who were employed by Reclamation in various program areas.

4. The Region has accessibility coordinators throughout all aspects of its operations to ensure program accessibility for the elderly and people with disabilities. There have been few, if any, complaints concerning reasonable accommodations or age discrimination in the provision of services.

Lower Colorado Region.—After September 11, 2001, the Hoover Dam Visitor Center Volunteer Program had to end and tours were suspended. To date, this program and its related activities gradually are being reactivated. It is anticipated that the Hoover Dam Ambassador Program will open in early spring 2004. This new program will call on services of volunteers to welcome visitors, distribute materials, assist tourists, and serve as liaisons with the community. It is expected that many of the volunteers will be senior citizens who were formerly associated with Reclamation's volunteer activities.

Boulder Canyon Operations.—Boulder Canyon updated its web site to provide the latest information on its policies and practices. The walkway approach to its Date Street Facility was improved for safety and accessibility reasons. The modifications proved to assist the elderly and people with disabilities substantially.

Pacific Northwest Region.—The Pacific Northwest Region utilized older and retired citizens as camp and park hosts each year at various field locations in calendar years 2001 and 2002. An elderly volunteer who was hired during the period as a temporary employee to accomplish clerical duties at the Area Office, remains an employee of the Bureau of Reclamation as of calendar year 2003.

The Centennial Job Corps employed an older worker under a temporary contract and expects to employ her in the very near future as a permanent employee. The Employee Development Office studied the feasibility to providing elder care web training for the benefit of its employees. The Regional Office also provided speakers on the topic of elder care during brown bag employee lunch sessions.

Upper Colorado Region.—In 2003, the Upper Colorado (UC) Region employed a total of 301 employees over 50 years of age. Of those employees, 58 were 62 years or older. A breakdown by age group is shown below:

Age group	Number of employees
51–54 years	160
55–59 years	83
60–70 years	56
70–80 years	2

The UC Region utilized five senior volunteers from the Green Thumb, Inc., organization during 2002. These volunteers donated their time and invaluable talents at the Weber Basin Job Corps in Ogden, Utah. In 2002, the UC Regional Office contracted with the Salt Lake County Aging Service and the Corporation for National Service to conduct the Retired and Senior Volunteer Program (RSVP). The RSVP matches skills, talents, and interests of individuals age 55 and over with Reclamation's volunteer staffing needs. The RSVP has proven to be invaluable in the recruitment of volunteers. The UC Region has participated in the Salt Lake County Aging Benefits Fair in calendar years 2001 and 2002 where information regarding employment opportunities were made available to individuals age 55 and over in the greater Salt Lake area.

The UC Region has two permanent members on Reclamation's Work Life Team. The team provides information to all employees on aging issues and family related issues. A newsletter also continues to be published that provides information regarding to aging, health and welfare among other concerns.

Recreation facilities in the Upper Colorado Region were upgraded to improve accessibility for the elderly and people with disabilities. In 2002, the following facilities were renovated to improve access: Crawford Reservoir, Colorado; Navajo Reservoir, New Mexico; Deer Creek Reservoir; Utah; and Scofield Reservoir, Utah.

U.S. Fish and Wildlife Service

The U.S. Fish and Wildlife Service (FWS) provides opportunities for all employees regardless of their age, but ensures that older individuals are utilized through special programs, volunteer programs, and employment opportunities. The Service reports the following activities on aging for 2001 and 2002.

2001

The FWS employed 8,357 individuals during the fiscal year. There were 5,656 (68%) Service employees age 40 or over, which was an increase of 27 employees from the previous year. Of the FWS employees over the age of 40, there were 327 (4%) over the age of 60, and increase of 3 employees from the previous year.

The majority of the FWS's mission related occupations, which include biologists, are in Professional positions. Demographic information regarding FWS employees over the age of 40 is as follows:

- 1,207 (14%) are in Administrative positions; 60 (0.7%) are over the age of 60;
- 805 (10%) are in Technical positions; 67 (0.8%) are over the age of 60;
- 346 (4%) are in Clerical positions; 40 (0.5%) are over the age of 60;
- 13 (0.2%) are in Other positions; none over the age of 60;

- 630 (8%) are in Wage Grade positions; 65 (0.8%)—are over the age of 60.

During the year, there were seven employment related discrimination complaints filed alleging discrimination on the basis of age (40 and above). Among the Federally Assisted Program related complaints filed, one contained an allegation of discrimination on the basis of age (40 and above).

A total of 8,332 Golden Age Passports were issued by the FWS in 2001. The Golden Age Passport Program provides free or lower entrance fees to most national parks, monuments, historic sites, recreation areas and national wildlife refuges for any individual over the age of 62. The FWS provided senior citizens with educational activities and with the opportunity to do volunteer work ranging from construction work to habitat restoration. Volunteers over the age of 61 were involved in FWS's fish and wildlife management programs such as leading school groups through national wildlife refuges, helping sample fish populations, staffing information desks, maintaining vehicles and equipment, and conducting bird and wildlife censuring. The FWS has purchased passengercarts that provide guided tours on the trail systems for people with limited mobility, also, special activities such as Trolley Tour, bird walks, duck identification workshops, and shellfish programs were organized for seniors and some recreational activities were provided free of charge. During the 2001 Older Americans Month, a speaker from the Senior Resource Center was invited to talk about issues related to aging and taking care of older parents.

The FWS recognizes the numerous contributions of older individuals through various awards programs. There were 4,225 FWS employees over the age of 40 who were recognized for their exceptional contributions through the FWS's Special Act or Service Awards.

2002

The FWS employed a total of 8,660 individuals. There were 5,902 (68%) of Service employees over the age of 40, which was an increase of 246 employees from the previous year. Of the FWS's employees over the age of 40, 389 (5%) were over the age of 60; an increase of 62 employees from the previous year.

The majority of the FWS's mission related occupations, which include biologists, are in Professional positions. Demographic information regarding FWS employees over the age of 40 is as follows:

- 2,834 (33%) were in Professional positions, 119 (1%) were over the age of 60;
- 1,313 (15%) were in Administrative positions, 78 (0.9%) were over the age of 60;
- 762 (9%) were in Technical positions, 76 (0.9%) were over the age of 60;
- 322 (4%) were in Clerical positions, 32 (0.4%) were over the age of 60;
- 10 (0.3%) were in Other positions, none were over the age of 60;
- 661 (8%) were in Wage Grade positions, 84 (1%) were over the age of 60.

During 2002, there were a total of 13 employment discrimination complaint alleging discrimination on the basis of age (40 and above) filed. Additionally, the FWS had three Federally Assisted Program related complaints alleging discrimination on the basis of age.

Approximately 8,500 Golden Age Passports were issued in 2002. The Golden Age Passport Program provides free entrance or lower entrance fees to most national parks, monuments, historic sites, recreation areas and national wildlife refuges for any individual over the age of 62. The FWS sponsored speakers that educated employees on issues related to health and aging during its Annual Diversity Day. The FWS also commemorated Older Americans Month with a host of activities in honor of elderly individuals. The FWS's Heritage Committee established a retiree organization. There are 2000 names on the list of the committee and the committee organizes and annual retiree union. Retirees have been integral to the FWS's history collection carrying out hundreds of oral histories and donating thousands of objects to the National Career Training Center archives. A 55-foot accessible ramp was added to the "Old School House" at Sherburne National Wildlife Refuge to provide access that benefits persons with limited mobility, many of which are older persons.

The FWS continues providing senior citizens with educational activities such as the Elderhostel volunteer program to perform volunteer work ranging from construction of a wildlife loop observation platform, pine thinning, and pony fence repair work to habitat restoration. Elder volunteers also work spreading mulch on the environmental education trails and sandstone on woodland trails. Pre-retirement seminars are provided to FWS employees annually.

The FWS recognizes the numerous contributions of older individuals through various awards programs. There were 3,790 employees age 40 or over who received Cash and other Incentive Awards to recognize their exceptional contributions to the FWS. The FWS provided Long Term Health Care Briefings and informational materials to employees.

U.S. GEOLOGICAL SURVEY

The U.S. Geological Survey (USGS) provides opportunities to all individuals throughout the bureau and ensures that the skills of older individuals are utilized through special programs and employment opportunities.

2001

In 2001, USGS employed a total of 10,279 individuals in permanent and temporary jobs. There were 6,927 (67.4%) USGS employees age 40 and over. Of USGS employees age 40 and over, there were 537 (7.7%) employees who were 60 years of age and older, and two employees over 80 years old.

There was an increase of 229 (2.3%) in employment totals for permanent and temporary jobs and for employees ages 40 and over [increased by 68 (1.0%)] and 60 and over [increased by 31 (6.1%)] from the last reporting period.

The majority of USGS' mission related occupations, which include occupations such as Hydologists, Geologists, Cartographers and Biologists, are in the Professional category. Of the 6,927 USGS employees age 40 and over, there were 3,706 (53.5%) in Professional positions, 311 (8.4%) of whom were age 60 and over, and one employee over 80. Other demographic information regarding USGS employees age 40 and over was as follows:

- 1,113 (16.1%) of employees 40 and over are in Administrative positions with 65 (5.8%) of them age 60 and over;
- 1,688 (24.4%) of employees 40 and over in Technical positions with 120 (7.1%) of them age 60 and over;
- 286 (4.1%) of employees 40 and over in Clerical positions with 34 (11.9%) of them age 60 and over;
- 25 (0.3%) of employees 40 and over are in other positions with none of them age 60 and over; and
- 109 (1.6%) of employees 40 and over are in Wage Grade positions with 7 (6.4%) age 60 and over.

There were two employees over the age of 80, one Wildlife Biologist and one Clerk Typist, both of whom worked full time.

In 2001, USGS selected participants for the following career development courses:

- Executive Leadership Program: Of 4 participants, 3 are age 40 and over;
- Team Leadership Program: Of 7 participants, 5 are over the age of 40; and
- Federal Executive Institute: Of 22 participants, 21 are over the age of 40.

Complaints 2001.—There were three (3) Federal equal employment complaints filed against the USGS based on age during calendar year 2001.

2002

In 2002, USGS employed a total of 10,441 individuals in permanent and temporary jobs. There were 7.048 (67.5%) USGS employees age 40 and over. Of USGS employees age 40 and over, there were 594 (8.4%) employees who were 60 years of age and older, and there were four employees over the age of 80.

There was an increase of 162 (1.6%) in employment totals for permanent and temporary jobs and for employees ages 40 and over [increased by 121 (1.7%)] and 60 and over [increased by 57 (10.6%)] from 2001 reporting period.

The majority of USGS' mission related occupations, which include positions such as Hydrologists, Geologists, Cartographers and Biologists, are in the Professional category. Of the 7,048 USGS employees age 40 and over, there were 3,770 (53.5%) in the Professional positions, 340 (9%) of whom were age 60 and over, and three employees over the age of 80. Other demographic information regarding USGS employees age 40 and over was as follows:

- 1,182 (16.7%) of employees 40 and over are in Administrative positions with 75 (6.3%) of them age 60 and over;
- 1,711 (24.3%) of employees 40 and over in Technical positions with 129 (7.5%) of them age 60 and over;
- 252 (3.6%) of employees 40 and over are in Clerical positions with 37 (14.7%) of them age 60 and over;

• 25 (0.4%) of employees 40 and over are in other positions with none of them age 60 and over; and

• 108 (1.5%) of employees 40 and over are in wage grade positions with 13 (12%) age 60 and over.

There were a total of four employees over 80 years of age, a cartographer, a wildlife biologist, a hydrologist, and a clerk typist. All four were full time employees.

In 2002, USGS selected participants for the following career development courses:

• Executive Leadership Program: Of 4 participants, 3 are over the age of 40; and

• Federal Executive Institute Program: 16 participants. All of the participants are over the age of 40.

Listed below are the numbers of individuals who retired from USGS, some of whom have continued to provide outstanding services to USGS and the public nationwide in a variety of capacities.

Categories	2001	2002
Retirees	161	162
Scientists Emeritus	225	230

The USGS Scientists Emeriti are welcomed back to the USGS after retirement to continue important scientific research. The USGS benefits immeasurably from the accumulated knowledge, experience, and dedication from the scientists.

Complaints -2002.—In 2002, there were 8 complaints filed based on age.

Volunteer Programs.—USGS has over 9,000 volunteers a year that participate in the various volunteer programs. Approximately, one third of the volunteers were over the age of 40.

Volunteer Program of the USGS Hawaiian Volcano Observatory (HVO). Dozens of volunteers contribute thousands of hours each year to help HVO's staff monitor the active volcanoes of Hawaii and conduct research on various aspects of Hawaiian volcanism. The volunteers in turn gain experience working on active volcanoes and participating in scientific research—collecting and analyzing data, building and installing instruments for experiments and volcano and earthquake monitoring, taking photographs and conducting surveys, and working on team or individual research projects.

Volunteers range from undergraduate students to retired educators, computer programmers to chemists, and writers to electricians. People come from around the world to volunteer at HVO. Hawaii's active volcanoes and natural beauty make the volunteer positions very popular and highly competitive.

HVO provides free lodging for as many as 7 volunteers at a time in a fully-furnished house about 4 kilometers from the Observatory. Volunteers staying in our guest house must be willing to work for at least three months on a full-time basis. Transportation is provided between the house and HVO, but volunteers are responsible for all non-work-related travel expenses (travel to and from Hilo, Hawaii, and travel on the Big Island and neighboring islands). Volunteers are also responsible for all food and health-care costs.

Many of the volunteer positions require work in the field, sometimes in remote areas of Hawaii Volcanoes National Park and other parts of the Big Island. For these positions, volunteers often must hike several kilometers over rough and irregular ground in hot, humid conditions, or sometimes in raw, bone-chilling cold and wet weather high on the volcanoes. Also, some of the field sites are near active fumaroles, and many sites are intermittently swept by the plume of sulfur dioxide gas from the Pu'u 'O'ovent the noxious plume poses a health hazard by aggravating preexisting respiratory ailments.

The North American Amphibian Monitoring Program (NAAMP) is a collaborative effort among regional partners, such as state natural resource agencies and nonprofit organizations, and the U.S. Geological Survey (USGS) to monitor populations of vocal amphibians. The USGS provides central coordination and database management. The regional partners recruit and train volunteer observers to collect amphibian population data, following the protocol of the NAAMP. Amphibian population data are collected using a calling survey technique in which observers identify local amphibian species by their unique vocalizations. Not all amphibian species make vocalizations, but many frogs and toads do. Observers are trained to identify their local species by these unique vocalizations of "frog calls."

Earth Science Corps.—The Earth Science Corps (ESC) is a field component of the USGS Volunteer for Science Program where volunteers may participate in USGS projects. USGS has an ongoing map annotation project where volunteers collect new information for use in the National Mapping Program.

- *ESC Volunteer Guide*—provides Map annotation instructions; and
- *Assigned Quadrangles Map*—shows USGS quadrangles already assigned to volunteers.

Listed below are some other programs that older Americans have made the following contributions to USGS operations: These programs can be found on the USGS' Web site (http://interactive.usgs.gov/Volunteer/USGSActivities/PhotoIndex.asp)

Volunteer sampling marsh sediments from a small boat; see *Access USGS San Francisco Bay and Delta*

Volunteers conducting migratory bird surveys, *Bird Monitoring in North America.*

Geologists and volunteer annotating a USGS map, see *How to Read a Topographic Map* and *Earth Science Corps Volunteer Guide.*

Scientists and volunteers monitoring coastal processes using a USGS research vessel, see *Environmental Quality and Preservation.*

Volunteer cooking in a remote field camp kitchen, see *Geologic Information About Alaska* and *Alaska Biological Science Center.*

Geologist, teacher, and student volunteers, see *USGS National Center Tour Information*, and Major *USGS Offices*.

Volunteer discovering a newly formed fault rupture, see *This Dynamic Earth*.

Volunteer taking cross-sectional slab from a tree trunk to be used for dendrochronology (tree ring dating), see *Tree Ring Images*.

Volunteers sampling glacier dust layer, see *Global Change Research Program*.

Scientists and volunteers unloading supplies from a float plane at remote research camp, see *USGS Western Region Geologic Information.*

Elderly Care Program. —There was a two-part Elder Care Workshop that was sponsored by the USGS Employee Assistance Program covering the options to be considered when creating a plan to serve aging family members in the best way possible. Information was provided about Medicare, Medigap, and Medicare HMO plans, and the legal issues related to elder care health needs.

As a follow-on to the workshop, an Elder Care Support Group was established which has continued to the present. The group meets regularly every month.

There were also workshops during 2001 and 2002 providing information on health issues related to aging including Alzheimer's disease, heart health, osteoporosis, and stroke.

Health screenings for health issues related to aging have been offered through the National Center Health Unit including stroke, heart disease, and osteoporosis screenings.

ITEM 9—DEPARTMENT OF JUSTICE

INITIATIVES RELATED TO OLDER AMERICANS 2001–2002

INTRODUCTION

The Department of Justice's Office of Justice Programs is actively involved in a number of activities to protect older Americans. In Fiscal Year 2001, OJP awarded $6,049,425 for efforts to protect the elderly, and more than $9 million in Fiscal Year 2002. The work of the following Office of Justice Programs components (the Bureau of Justice Assistance, the Office for Victims of Crime, the Office on Violence Against Women, the Executive Office for Weed and Seed, the National Institute of Justice, and the Bureau of Justice Statistics) to protect older Americans is highlighted below.

Preventing Fraud Against the Elderly

The Office of Justice Programs' Bureau of Justice Assistance (BJA) continued its activities under the Telemarketing Fraud Prevention and Public Awareness Program. This program began in 1997 and is supported by an annual $2 million congressional appropriation for "programs to assist law enforcement in preventing and stopping marketing scams against senior citizens." The program is intended to support federal, state, and local efforts among law enforcement, crime prevention, victim assistance, consumer protection, adult protective services, and programs that serve older people in implementing public education and training efforts.

Under this program, BJA created a Telemarketing Fraud Training Task Force made up of the National Association of Attorneys General, the American Prosecutors' Research Institute, the National White Collar Crime Center and AARP. The Task Force's purpose is to develop and provide training for state and local investigators and prosecutors and to develop public awareness materials to thwart fraudulent telemarketers who prey on senior citizens. Since 1998, the Task Force has sponsored approximately 12 regional training conferences.

In addition, the following activities were conducted. In Los Angeles, the California Department of Corporations continued Operation Tough Call, a command post and clearinghouse through which local, state, and federal law enforcement and regulatory agencies coordinate enforcement efforts against fraudulent telemarketing activity. In Atlanta, the Georgia Governor's Office of Consumer Affairs created a task force to fight telemarketing fraud, as did the Hillsborough County State Attorney's Office in Tampa. The North Carolina Office of the Attorney General in Raleigh hired an investigator to expand prosecution of fraudulent telemarketing companies and to educate the public and key industries on how to

identify and stop telemarketing fraud. In Montpelier, the Vermont Office of the Attorney General increased its prosecutory and investigatory resources and continued to build ties with Canada by working with the National Association of Attorneys General to establish investigative liaison relationships.

The task force also conducted training sessions in Seattle, Cleveland, and Durham, North Carolina, attended by prosecutors, investigators, and victim advocates from throughout the United States and Canada. In Illinois, the state police continued their innovative Financial Exploitation of the Elderly Unit. Investigators with the unit serve as advocates who help report, investigate, and prosecute perpetrators of financial crimes against the elderly. They also educate elderly people on what constitutes financial abuse.

BJA funding for the National Consumers League (NCL) provided local law enforcement agencies with tools to conduct effective public education programs aimed at preventing telemarketing fraud. NCL's primary objectives are to empower consumers to avoid victimization, encourage victims to report fraud crimes, develop and disseminate a Telemarketing Fraud Education Kit to law enforcement agencies, and participate in public forums, such as radio programs, to heighten awareness of telemarketing crime.

In addition, in FY 2001, the Office for Victims of Crime (OVC) continued to support state and local efforts to provide public education and training related to telemarketing fraud. Funded projects include:

- training and information (utilized nationwide) on fraud for bank personnel throughout the state of Oregon and services for older fraud victims;
- a national, coordinated public education and awareness and training effort among the National Sheriffs' Association and a range of organizations and corporations, including the AARP, the National Association of Attorneys General, the National District Attorneys Association, Triad, state sheriffs' associations, and Radio Shack; and
- a public education campaign by the National Hispanic Council on Aging to combat telemarketing fraud in the Latino community.

Preventing Elder Abuse

Domestic violence and sexual assault affect victims in all age groups. However, older individuals who are victimized by these crimes face additional challenges in receiving the services they need to obtain safety. Law enforcement officers and other first responders may not recognize them as victims of intimate partner violence and consequently may not take necessary actions to ensure their safety. Appropriate interventions may be compromised by misconceptions that older persons are incapable of inflicting serious harm on their intimate partners or that the abuse is simply an expression of the stress associated with caring for an aging partner. Age or disability may increase the isolation of victims of domestic violence or their dependence on abusers for care or housing.

In addition, an abuser may threaten institutionalization to prevent victims from seeking help or calling the police. These cases may go unnoticed because criminal justice system personnel may

be less likely to perceive a victim's injuries as arising from aging, frailty, illness or disability rather than from abuse. For example, an older woman's broken bones may be attributed to disorientation or osteoporosis without any inquiry about violence in the home. The Office on Violence Against Women (OVW) is working to provide training from criminal justice system personnel to address these barriers and improve systemic responses to older victims and victims with disabilities.

OVW awarded an FY 2001 grant of $500,000 to the Wisconsin Coalition Against Domestic Violence (WICADV) to continue operation of the National Clearinghouse on Abuse in Later Life (NCALL), which was established as a technical assistance project with an OVW award in FY 1999. With OVW support, NCALL has provided model materials, interactive training, and consultation on working with older victims. With the FY 2001 award, the project worked to address the complex issues that arise from the intersection of the respective policies, protocols, and philosophies of domestic violence victim advocacy organizations and elder abuse agencies. These include addressing mandatory reporting laws, victim safety and autonomy concerns, issues specific to abused women with disabilities, and the development of response protoctols for domestic violence programs serving older victims. NCALL also continued to provide the services of its clearinghouse in collaboration with the American Bar Association (ABA), the National Association of Adult Protective Service Administrators (NAAPSA), and the Wisconsin Coalition Against Sexual Assault (WCASA).

In Fiscal Year 2002, the Office on Violence Against Women implemented a new discretionary grant program to support training for law enforcement officers, prosecutors, and relevant officers of federal, state, tribal, and local courts that specifically addresses the obstacles encountered by victims of crimes who are older individuals or persons with disabilities. This program was authorized by the Violence Against Women Act of 2000, which states that:

The Attorney General may make grants for training programs to assist law enforcement officers, prosecutors, and relevant officers of Federal, State, tribal and local courts in recognizing, addressing, investigating, and prosecuting instances of elder abuse, neglect, and exploitation and violence against individuals with disabilities, including domestic violence and sexual assault, against older or disabled individuals. [42 U.S.C. 14041(a)]

Congress appropriated $5 million for the FY 2002 Training Grants to Stop Abuse and Sexual Assault Against Older Individuals or Individuals with Disabilities Discretionary Grant Program. After setting aside funds for evaluation, technical assistance, solicitation, peer review, and other management and administration costs, the Attorney General awarded approximately $4.5 million to 18 grantees for FY 2002.

The Training Grants to Stop Abuse and Sexual Assault Against Older Individuals or Individuals with Disabilities program provides a unique opportunity for targeted training for law enforcement officers, prosecutors and relevant court officers to enhance their ability to recognize, address, investigate, and prosecute these serious crimes. The way individuals cope as victims may depend on their experiences following the crimes committed against them. As part

of the civil and criminal justice system, law enforcement officers, prosecutors, and court officers are in a position to help victims cope with the immediate trauma of crime and ensure that offenders are held accountable as well as to help in restoring victims' sense of security and control over their lives. The training is designed to help civil and criminal justice system personnel understand that older victims or victims with disabilities both require compassionate and comprehensive services and also may face unique challenges.

Using these Training Grants funds, the California District Attorneys Association developed and distributed a video-formatted training on "Forensic Wound Identification and Links to Successful Criminal Investigation and Prosecution." Vera House in New York City has supported a coordinated community response intervention for older individuals who are victimized. The Technical Assistance provider for this grant program, the Wisconsin Coalition Against Domestic Violence, is working with the National Clearinghouse on Abuse in Later Life to develop a directory of services available for victims of elder abuse and a guide for creating support groups for such victims.

In addition, the Violence Against Women Act (VAWA) of 2000 added a purpose area to OVW's Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program and the STOP Violence Against Women Formula Grants Program that encourages grantees to develop or strengthen policies and training for police, prosecutors, and the judiciary in recognizing, investigating, and prosecuting instances of domestic violence and sexual assault against older individuals and individual's with disabilities. For example, one Arrest Program grantee, the local prosecutor's office in Skagit County, Washington, provided training for criminal justice personnel and domestic violence practitioners on investigating and prosecuting abuse and neglect cases.

Domestic violence victims face formidable obstacles when attempting to leave abusive relationships, seek assistance, and obtain safety. For older victims and victims with physical and/or mental disabilities, these tasks can prove especially daunting. Service providers and criminal justice personnel may lack experience meeting the specific needs of older and disabled victims. Also, these victims may be particularly isolated by communication barriers, physical barriers, and the exploitation of their age or disability by their abusive partners.

With OVW support, including an FY 2001 award of $75,000, the Statewide California Coalition for Battered Women is developing two separate training curricula to enhance services to victims of both domestic violence and sexual assault who are older or disabled. The curricula will be used to train state domestic violence and sexual assault coalitions, STOP Violence Against Women Formula Grant program administrators, and STOP subgrantees in 13 states. The project features strong partnerships with organizations with the expertise necessary to successfully implement such an initiative.

Assisting Elderly Crime Victims

Each year, the Office for Victims of Crime (OVC) awards Victims of Crime Act (VOCA) funds to states to support community-based organizations that serve crime victims. States subgrant these funds to support domestic violence shelters, rape crisis centers, child abuse programs, and victim service units in law enforcement agencies, prosecutors' offices, hospitals, and social service agencies. These programs provide services such as crisis intervention, counseling, emergency shelter, criminal justice advocacy, and emergency transportation.

States and territories receiving VOCA funds are required to give priority to programs serving victims of domestic violence, sexual assault, and child abuse. Additional funds must be set aside for under-served victims, such as victims of elder abuse. In Fiscal Year 2001, VOCA victim assistance programs provided services to 31,240 victims of elder abuse. In Fiscal Year 2002, 29,939 victims of elder abuse received services. Further information about OVC resources, including links to organizations that serve elderly crime victims, is available on the OVC Web site at www.ojp.usdoj.gov/ovc.

OVC also directly supported a number of initiatives to assist elderly crime victims. In April 2002, OVC awarded grants of approximately $200,000 each to the Denver District Attorney's Office, Legal Services of Eastern Michigan, and Sam Houston State University in Huntsville, Texas, to help improve services for older victims of fraud. The grantees are developing innovative research, training, and materials that OVC will distribute to law enforcement officers, victim service providers, and other professionals who work with older adults.

With OVC support, the Denver District Attorney's Office is partnering with faith-based organizations to serve 40,000 elderly in the Denver area through efforts such as sending weekly financial crime prevention messages, training volunteers to work with victims, and improving financial crime reporting. It also hired a community advocate to work with the faith-based organizations to encourage the detection and reporting of elder fraud cases.

Legal Services of Eastern Michigan, based in Flint, is developing a comprehensive elder fraud training program covering predatory lending, home solicitation, financial exploitation, and telemarketing fraud. The training can be modified for many different types of participants, such as law enforcement officers, bankers, and senior care center directors.

Sam Houston State University's National Institute for Victim Studies is examining the relationship between natural disasters and elder financial exploitation, using Tropical Storm Allison in Texas and tornadoes in Kansas and Oklahoma as models. The University also is examining the types of information available to older people to warn them about fraud in the wake of natural disasters.

OVC also awarded an FY 2001 grant to the American Bar Association, working in conjunction with the National Association of Adult Protective Services Administrators, for an initiative to enhance the development of multi-disciplinary fatility review teams in the area of elder abuse. The project will include support for four demonstration projects and development of a replication guide.

Under OVC grants awarded in FY 2001 and 2002, the Baylor College of Medicine in Texas is developing and testing a curriculum to train physicians, medical students, and other health professionals working in fields such as emergency medicine, geriatrics, family practice, and internal medicine on elder abuse. The curriculum, which is being designed for national replication, covers the nature of victimization, screening, assessment, appropriate interventions, reporting, and working with adult protective services and the criminal justice system. The grantee is conducting training on this curriculum at all medical schools in Texas, as well as at least one additional medical school elsewhere in the country. The project also will generate a publication for the field highlighting the work that is being done by Baylor's TEAM Institute, a partnership between the medical school and adult protective services dedicated to identifying and responding to victims of elder abuse.

OVC is supporting the update of a 1993 curriculum entitled "Improving the Police Response to Elder Abuse." The curriculum will be updated for reflect new research findings, the accumulated practical experience of criminal justice professionals and others in investigating and prosecuting abuse cases, and trainers' experiences in presenting the materials to law enforcement audiences.

OVC also provided funding to the American Bar Association to develop two curricula relating to elder abuse. The first is for use in training lawyers on responding to elder abuse and domestic violence; the second is to train victim advocates in providing direct services to victims of elder abuse.

In addition, OVC provided support for a December 2001 national conference convened by the National Center on Elder Abuse which brought together national experts from a wide range of fields to develop a national agenda for addressing elder abuse. The summit was co-sponsored by the Administration on Aging of the U.S. Department of Health and Human Services.

Improving Safety and Services for Seniors

Seniors citizens play an important role-both as volunteers and as consumers-in the more than 200 Weed and Seed programs operating throughout the country. Supported by OJP's Executive Office for Weed and Seed (EOWS), Weed and Seed is a strategy that aims to prevent, control, and reduce violent crime, drug abuse, and gang activity in targeted high-crime neighborhoods. The strategy involves a two-pronged approach: law enforcement agencies and prosecutors cooperate in "weeding out" criminals who participate in violent crime and drug abuse, attempting to prevent their return to the targeted area; and "seeding" brings human services to the area, encompassing prevention, intervention, treatment, and neighborhood revitalization. A community-orientated policing component bridges weeding and seeding strategies.

The following are examples of Weed and Seed initiatives to improve safety and services for senior citizens:

- Midcoast Weed and Seed in Bath, Maine, is working with the local TRIAD chapter to prevent elder abuse and improve coordination of services to the elderly. TRIAD encourages partnerships among senior citizens, sheriffs, and police to address elder safety issues and enhance delivery of law enforcement

services to seniors. Midcoast Weed and Seed and TRIAD formed the Elder Abuse Task Force to raise community awareness of elder abuse, teach the community how to report and respond to such abuse, and develop and strengthen systems that support elderly victims and their families.

- The Santa Ana Interagency Neighborhood Team (SAINT) in Santa Ana, California, operates the Corbin SeedTech Computer Lab to help area residents gain the technological skills they need to complete in the job market. The lab offers morning classes for senior citizens.
- As pastor of the World Fellowship Interdenominational Church in Youngstown, Ohio, 100-year old Reverend Elizabeth Powell provides a number of community services, including operating a Safe Haven program for neighborhood youth. Because of her service to Weed and Seed and other community efforts throughout the years, in 2001, Reverend Powell was inducted into Ohio's Women's Hall of Fame.

Evaluating Elder Abuse Interventions

The National Institute of Justice (NIJ) is the research and evaluation arm of the Department of Justice. As such, NIJ commissions research projects in a variety of areas, including crimes against the elderly, and participates with federal partners, such as the National Academy of Sciences, on related research.

In addition, NIJ is working to fulfill the requirements of the Protecting Seniors from Fraud Act (P.L. 106–534). In response to Section 5(b)(1), NIJ is developing the research methodology and is formulating a questionnaire to determine the scope and nature of crimes against seniors, paying particular attention to telemarketing, sweepstakes, and repair fraud. NIJ researchers will develop the questionnaire and contract with a survey research firm to conduct the survey. When the survey is completed, NIJ will analyze the data and report on the conclusions.

NIJ is also represented on the Administration on Aging's study planning committee to define "exploitation" and "fraud" so that AoA's congressionally-mandated study and NIJ's study complement rather than duplicate each other.

In September 2001, NIJ issued a Research in Brief on "Results from an Elder Abuse Prevention Experiment in New York City," by Robert C. Davis and Juanjo Medina-Ariza. Support for this project was provided through a transfer of funds to NIJ from the Office of Community Oriented Policing Services (COPS). The brief discussed a field experiment of an intervention to reduce repeat incidents of elder abuse. Households in randomly selected public housing projects in New York City received educational material about elder abuse, while others did not. Some households that reported elder abuse to the police were selected by lottery to receive a follow-up home visit from a police officer and a domestic violence counselor. Data on post-report abuse were collected at six and 12 months after the initial report to the police.

The study found that new incidents of abuse were more frequent among households that both received home visits and were in housing projects that received public education. Households that received home visits also called the police significantly more often

than controls, both in the housing projects that received public education and in those that did not. When households both received home visits and were in housing projects that received public education, victims of elder abuse reported significantly higher levels of physical abuse to research interviewers (compared with households that received neither intervention or only one of them). The researchers speculated that the study interventions actually incited abusers, rather than deterring them. Full study findings are available at the NIJ Web site at: www.ncjrs.org/txtfiles1nij/188675.txt.

Improving Data Collection

The Protecting Seniors from Fraud Act (P.L. 106–534) required the Bureau of Justice Statistics (BJS) to include in its National Crime Victimization Survey (NCVS) statistics relating to:

(1) crimes targeting or disproportionately affecting seniors; (2) crime risk factors for seniors, including the time and locations at which crimes victimizing seniors are most likely to occur; and (3) specific characteristics of the victims of crimes who are seniors, including age, gender, race or ethnicity, and socioeconomic status.

To meet the requirements of Section 5(b)(1)(A) and Section 6 (data on nature and type of crimes against the elderly and NCVS statistics on crimes affecting seniors), BJS published *Crimes Against Persons Age 65 or Older, 1992–97.* This publication is available on the BJS Web site at www.ojp.usdoj.gov/bjs/. The report provides data from the NCVS, as well as from the FBI Uniform Crime Reports. It summarizes levels and rates of violent and property crimes against persons age 65 or older and provides information on the victimization of the elderly, but does not include the crime of fraud. BJS and NIJ are working to determine if fraud data can be obtained through the FBI's National Incident Based Reporting System (NIBRS).

Section 5(b)(4) requires the Attorney General to determine "the feasibility of States establishing and maintaining a centralized computer database on the incidence of crimes against seniors that will promote the uniform identification and reporting of such crimes." This requirement is being addressed through NIBRS, BJS and the FBI are encouraging states to adopt NIBRS in place of the Uniform Crim Reports System because NIBRS is a more comprehensive crime reporting system. The agencies have provided grants to assist states in making this change.

BJS and NIJ are also working together to determine how best to address the requirements of Section 5(b)(3), (5), and (6). Specifically the legislation requires the Attorney General to study "the manner in which the Federal and State criminal justice systems respond to crimes against seniors"; the "effectiveness of damage awards in court actions and other means by which seniors receive reimbursement and other damages after fraud has been established"; and "other effective ways to prevent or reduce the occurrence of crimes against seniors.

Though these and other initiatives, the Office of Justice Programs is working to protect seniors and provide appropriate services for elderly victims of crime. Further information about OJP funding programs and other resources is available from the OJP

Web site at www.ojp.usdoj.gov or by calling the Department of Justice Response Center toll free at 1–800–421–6770.

ITEM 10—DEPARTMENT OF STATE

ACTIVITIES IN CALENDAR YEARS 2001 AND 2002 IN SUPPORT OF OLDER AMERICANS

The Department is pleased to report that we continued to support aging Americans and their caregivers during 2001 and 2002. Department efforts focus on employee caregivers. Over the last decade the relationship between work and family has become more intertwined. Given that 25 percent of U.S. households are providing care to elderly loved ones, that 64 percent of caregivers are employed, and that 65 percent of caregivers are aged 35–64 while the average age of Department employees is 46, the Department recognizes that the burden of adult care is increasingly falling on employees in the workplace. To help employees be more effective at work and at home, the Department maintains an extensive Eldercare Program.

In 1999 the Department of State established an Eldercare Coordinator position in the Office of Employee Relations to develop and promote a series of initiatives to significantly improve the level of support the Department offers to employees with caregiving responsibilities for parents and other elderly relatives. The Coordinator formed a working group to conduct a policy review that considered caregiving issues identified by the American Foreign Service Association, by the Associates of the American Foreign Service, Worldwide (AAFSW) at an AAFSW-organized Eldercare Forum held at the Department, and the Director General of the Foreign Service and Director of Personnel of the Department.

The Eldercare Working Group studied the unique needs of both Civil Service and Foreign Service employees as well as current rules, regulations and practices with a major impact on caregivers. It devised an Eldercare Mission Statement to guide the development of Department eldercare support policy and recommended the establishment of a dependent care resource and referral service, a reinvigorated information program at Washington headquarters, and several major regulatory changes that could help caregiving employees who serve at overseas posts.

The Eldercare Mission Statement, which was accepted by unions that represent Department Civil Service and Foreign Service employees, continues to serve as a guide to developing a coordinated eldercare support program. The Statement says, "The Department recognizes that growing numbers of employees will have caregiving responsibilities for parents and other elderly relatives. To enable employees to make better decisions for the well being of their families, the Department will endeavor to provide information on available supports and services that affect the elderly. For employees serving abroad, it will also seek ways consistent with budget con-

straints to make available certain allowances and other benefits that assist in defraying additional eldercare costs due to service overseas. In Washington, the Department will provide a professionally-led eldercare support group, current and useful information on resources, and referral to community support services in the metropolitan area."

The two major innovations, a dependent care resource and referral service (known as IQ: INFORMATION QUEST since the fall of 2002) and a new travel benefit for Foreign Service employees when a parent faces a health crisis that may threaten continuing independence have both been well-received by employees. Since its implementation in January 2001, the Incapacitated Parent Emergency Visitation Travel benefit has been used by over 500 employees or their eligible spouses who are serving at American missions abroad. In many cases employees who combined the referral service and travel benefit were able to respond to a parent's health crisis quickly and put in place a plan of care using appropriate programs and services available in the community where their parents lived. These Department-provided tools relieve the stress of very long-distance caregiving and help needy parents who depend on their children working at American missions abroad.

In May 2000, the Department contracted with LifeCare.com to provide dependent care resource and referral services to employees assigned both domestically and abroad. While this service provides referral service on a full range of dependent care issues, including child care, it has been a valuable source of assistance to employees called upon to make decisions concerning the care and well-being of aging parents. Over 2000 Department employees have used the service to learn about creating an effective plan of care or to find adult care resources in the community where their parents live.

The Employee Consultation Service, the Department's employee assistance program, continued to offer counseling and referral and facilitated an ongoing Eldercare Support Group with weekly meetings for employees in the Washington area. The Family Liaison Office advocated within the Department on behalf of Foreign Service employees and family members with caregiving issues arising out of high international mobility.

The Office of Employee Relations organized a bimonthly lunchtime seminar series called "Caring for Your Aging Parents" which provided information on legal issues of aging, long-distance-caregiving, housing options for the elderly, coping with Alzheimer's Disease, respite care, and more, as well as promoted the use of IQ: INFORMATION QUEST, the dependent care referral service.

ITEM 11—DEPARTMENT OF TRANSPORTATION

SUMMARY OF ACTIVITIES TO IMPROVE TRANSPORTATION SERVICES FOR THE ELDERLY

INTRODUCTION

The following is a summary of significant actions taken by the U.S. Department of Transportation during calendar years 2001 and 2002 to improve transportation for elderly persons.[1]

DIRECT ASSISTANCE

FEDERAL TRANSIT ADMINISTRATION (FTA)

Under 49 USC 5310, the FTA provides assistance to private nonprofit organizations and certain public bodies for the provision of transportation services for the elderly and persons with disabilities. In FY 2001, $175 million was used to help 1,407 local providers purchase 2,212 vehicles and for contracted services. In FY 2002, $140 million was used to help 1,447 local providers purchase 2,179 vehicles and for contracted service for the provision of transportation services for the elderly and individuals with disabilities. Most of the agencies funded under the elderly and persons with disabilities program are either disability service organizations or elderly service organizations, and service provided under the program is nearly equally divided between the two. Those agencies servicing the elderly are, however, more dependent on funding from the elderly and persons with disabilities program as 53 percent of their vehicles are purchased with Section 5310 funds compared to 42 percent of vehicles purchased by agencies serving persons with disabilities. Vehicles purchased with these funds may also be used for meal delivery to the homebound as long as such use does not interfere with the primary purpose of the vehicles.

Under 49 USC 5311, the FTA obligated $214 million in FY 2001 and $275 million in FY 2002. These funds were used for capital, operating, and administrative expenditures by state and local agencies, nonprofit organizations, and operators of transportation systems to provide public transportation services in rural and small urban areas (under 50,000 population). The nonurbanized area program funds are also used for intercity bus service to link these areas to larger urban areas and other modes of transportation. An estimated 36 percent of the ridership in nonurbanized systems is

[1] Many of the activities highlighted in this report are directed toward the needs of persons with disabilities. However, one-third of elderly persons have disabilities and thus are major beneficiaries of these activities.

elderly, which represents nearly three times their proportion of the rural population.

Under 49 USC 5307, the FTA obligated $4.1 billion in FY 2001 and $4.3 billion in FY 2002. These funds were used for capital and operating expenditures by transit agencies to provide public transportation services in urbanized areas. While these services must be open to the general public, many elderly individuals depend on public transportation in urbanized areas.

Section 3038 of the Transportation Equity Act for the 21st Century authorized a program to fund the incremental capital and training costs of complying with DOT's over-the-road bus accessibility final rule. In FY 2001, $4.7 million was provided to 61 providers of intercity fixed-route service. These funds were used to make 138 vehicles wheelchair accessible and for training. In FY 2002, $7.1 million was provided to 73 providers of intercity fixed-route service and others, including charter and tour operators. These funds were used to make 217 vehicles wheelchair accessible and for training. Approximately 25 percent of the over-the-road bus industry's ridership is elderly, and a large proportion of persons who use wheelchairs are elderly. Providers of over-the-road bus services are encouraged to use accessibility training resources developed by the National Easter Seal Society's Project Action, an FTA-funded organization established to promote cooperation between the disability community and transportation industry.

FEDERAL RAILROAD ADMINISTRATION (FRA)

The National Railroad Passenger Corporation (Amtrak) continued throughout calendar years 2001 and 2002 to provide discounted fares, accessible accommodations, and special services, including assistance in arranging travel for older citizens and passengers with disabilities. These passengers continue to represent a substantial part of Amtrak's ridership - in 2002 ridership among seniors age 62 or older totaled approximately 1.7 million travelers.

Discounted Fares.—Amtrak has a system wide policy of providing elderly persons and persons with disabilities a 15 percent discount on ticket purchases. During this period, Amtrak also offered a 15 percent discount to adult companions traveling with a passenger with a mobility impairment. This 15 percent discount cannot be combined with any other discount. Amtrak also offered passengers with mobility impairments a 30 percent discount on the standard fare for accessible bedrooms.

Accessible Accommodations.—Amtrak provides accommodations that are accessible to elderly persons and passengers with disabilities, including those using wheelchairs, on all of its trains. Long-distance trains include accessible sleeping rooms as well as accessible coach seating and bathrooms. Short-distance trains, including Northeast Corridor trains, have accessible seating and bathrooms. Existing cars have been modified to provide more accessible accommodations and all new cars, including the Acela Express high-speed rail cars, provide enhanced accessibility for passengers with mobility and other types of disabilities. Amtrak allows only passengers with mobility impairments to reserve an accessible bedroom up until 14 days prior to the date of a train's departure from the city of origin.

Mechanical lifts operated by train or station staff provide passengers with access to single-level trains from stations with low platforms and short plate ramps provide access to bi-level equipment. An increasing number of Amtrak stations are fully accessible, particularly key intermodal stations that provide access to commuter trains and other forms of transportation.

Special On-Board Services.—Amtrak continues to provide special on-board services to elderly persons and passengers with disabilities, including aid in boarding and deboarding, special food services, written menus, special equipment handling, and provisions for wheelchairs. Amtrak has also improved training of its employees to enable them to respond better to passengers with special needs. It is recommended that passengers advise Amtrak of any special needs they may have in advance of their date of departure.

Assistance in Making Travel Arrangements.—Amtrak has available publications describing its services and facilities for the benefit of passengers with disabilities. A pamphlet entitled "Access Amtrak: A Guide to Amtrak Services for Travelers with Disabilities" is available upon request. Persons may request special services by contacting the reservations office at 1–800–USA–Rail. This office is equipped with text telephone (TTY) service for customers who are deaf or hard of hearing. To ensure that passengers receive the assistance they need, Amtrak maintains a Special Services Desk, which supports its reservations agents seven days a week. This desk has completed successful responses to 162,000 requests for special services. Passengers may also inform their travel agent or the station ticket agent of their assistance requirements when making travel reservations.

RESEARCH

DEPARTMENT–WIDE AGING INITIATIVE

Safe Mobility for a Maturing Society: Challenges and Opportunities.—To prepare the nation's transportation system for the near doubling of older Americans expected between now and 2030, the Department is developing strategies to advance safe mobility for older Americans in the first decades of the new century. The U.S. Department of Transportation Office of the Secretary, National Highway Traffic Safety Administration (NHTSA), Federal Highway Administration (FHWA), and Federal Transit Administration (FTA) are participating in this effort. The strategies are based on a national dialog on the transportation needs of an aging population. This dialog has included regional forums, workshops, professional society meetings, international conferences, and the work of a companion study done by the Transportation Research Board (see below). Its purpose has been to get the broadest possible viewpoint from those practicing in the field—transportation professionals, medical and social service providers, public officials, and the agencies and interest groups who deal with the elderly on a day-to-day basis. Concurrent with the regional forums a series of focus group discussions were held with older people and their lay care givers (usually adult children) to obtain their perspectives on elderly driving, the difficulties associated with driving cessation and the use

of other transportation options. Several telephone surveys of older adults were also conducted.

The result of this effort points out that there is no simple solution, nor is responsibility vested in one single organization. It has shown that a comprehensive set of strategies to manage safe transportation for our older adults is needed. Research has also indicated that there is an array of possible innovations and measures for maintaining transportation safety and quality of life for older adults: improved roads, safer cars, better driver screening and retraining, more access to non-driving alternatives, and dissemination of better information to the public. The Department is developing a source of guidance on the strategies that hold the most promise by transportation planning, law enforcement, social service, and medical agencies at all levels, as well as the private sector, and by older adults themselves and their advocates.

Transportation Research Board (TRB) Report.—The TRB, with the support of the Department, is working to update a 1988 report on needed research covering transportation for older adults. The update examines what has been done since 1988, what the requirements are for new work, and what the new research priorities should be for meeting the needs of an increasing elderly populace over the next 25 years. This report, Transportation for an Aging Society - a Decade of Experience will be published by TRB in late 2003.

FEDERAL AVIATION ADMINISTRATION (FAA)

The Office of Aerospace Medicine's Civil Aerospace Medical Institute (CAMI) has contributed to the following research related to the needs and concerns of the aging population in aviation transportation.

Cognitive Function Test.—Results of the study involving the administration of the CogScreen test to a group of older military aviators, including repatriated military aviations and a control group were presented during the XXV International Congress of Applied Psychology in 2002. The validation extends the age groups of the original CogScreen validation to include more aviators in the older age groups. The results were recently reanalyzed to combine several of the variablesusing factors identified in previous research on pilot age and performance. The general pattern of lowered CogScreen scores with advancing age was evident in the various factors.

Age-60 Rule.—In response to a complaint filed under the Department of Transportation (DOT) Information Dissemination Quality Guidelines, CAMI scientists provided a response regarding the four Age 60 rule studies that were completed by CAMI scientists in 2000, in response to the Congressional request.

To resolve issues that were raised regarding the Age 60 studies, a research study was initiated to evaluate the methodology involved in the identification and selection of the pilot population in these investigations. The draft report of this study is currently under review. Preliminary findings of the study indicate that factors such as the criteria for pilot and accident inclusions, estimation of exposure, and the analytic strategy are extremely important in studies of the relationship of airplane accidents with age.

Air Traffic Services-related Research.—As part of a continuing program of research on the effects of shift schedules on sleepiness, fatigue and performance in air traffic controllers, data were gathered from Certified Professional Controllers (CPCs) at a terminal radar control facility and an Air Route Traffic Control Center. Groups of controllers at the two facilities provided responses to questionnaires, logbooks, wrist activity monitors, and computerized tests assessed during the workday. A report from this research is currently under preparation. Outcomes were consistent with changes found in the general population; younger participants (<40 years of age) were significantly faster and had greater thruput on the computerized tasks that assessed Speed/Working Memory. Declines in subjective alertness of older controllers appeared to have a greater effect on speed/working memory task performance than in younger controllers. Results provide additional information to guide development of fatigue countermeasures for controllers and other personnel working rotating shift schedules.

In response to Congressional language in a current draft of the appropriation bill, CAMI scientists have been asked by the Air Traffic Service to initiate research designed to determine whether the mandatory age 56 separation requirement for air traffic control specialists should be maintained. Following discussions with personnel from air traffic services, a set of research studies may be initiated.

FEDERAL HIGHWAY ADMINISTRATION (FHWA)

Beginning in 1989, a High Priority Area for research was established to develop a clear understanding of older driver needs and capabilities with respect to the roadway environment. Research under this program started as problem identification, and quickly moved to focus on the specific areas that cause the greatest problems for older drivers and pedestrians.

Research findings from this program are incorporated in an updated version of the Older Driver Handbook that was completed in October 2001. Besides including the most recent research findings, this document addresses a broad range of highway design areas. The new editions: (i.e., *Highway Design Handbook for Older Drivers and Pedestrians (FHWA-RD–01–103) and Guidelines and Recommendations to Accommodate Older Drivers and Pedestrians* (FHWA–RD–01–051)) now available in hard copy or in electronic form via the Internet.

FHWA is participating in an international organization concerned with the older population (i.e., Organization for Economic Co-operation and Development (OECD)) via membership on "Human Factors of Technology for Elderly Users" Working Group. FHWA is also participating in the OECD 2003 Symposium on "Human Factors of Transport Technology for Older Persons."

It should be noted that all human centered research, including Intelligent Transportation Systems initiatives, conducted by FHWA includes an older driver component to ensure the system's utility for all potential users.

The FHWA is continuing work to fulfill a mandate issued by Congress that requires public agencies to maintain signs and pavement markings to minimum levels of retroreflectivity (i.e., bright-

ness). In the process of establishing these minimum guidelines, research has been conducted to determine the brightness of signs and pavement markings necessary for older drivers to drive safely and comfortably at night. A recent study using older drivers as subjects, has determined an optimum brightness for overhead guide signs.

Two laboratory simulator experiments and one field validation study on minimum retroreflectivity requirements and luminance trading relationships for pavement markings (i.e., center lines and edge lines) and retroflective raised pavement markers have been conducted utilizing older drivers. Two additional roadway delineation studies experiments are planned for next year. Both of these studies, which will examine driver performance as they navigate curves at night, will also utilize older drivers.

The FHWA, in cooperation with Virginia Department of Transportation (VDOT), is also evaluating the ability of various pavement marking materials to provide adequate guidance to older drivers under wet night conditions. The experiment will be conducted on a new stretch of roadway at the Virginia Smart Road, by researchers at the Virginia Tech Transportation Institute.

Research is presently underway that will examine the proportion of fluorescence to reflectance needed to attain enhanced visibility of signs in daytime, and to study the effects of sign color fading due to weather. Older drivers will be used exclusively as research participants in these studies.

FHWA is also investigating the effectiveness of new automobile headlight systems, which have the potential to drastically improve the visibility of signs, pavement markings, and pedestrians at night. Older drivers have been included in the experiments involving ultraviolet and infrared headlighting systems, and other new headlamp technologies. Efforts are continuing on this project to evaluate driver visibility with these headlight systems under adverse weather conditions at the Virginia Smart Road, and to determine the possible impacts of glare on other drivers while using these new headlighting systems.

The FHWA also used the Virginia Smart Road and its sophisticated fixed lighting test system to examine varying light types, levels, and placement to identify optimum lighting design for older drivers. Ninety older drivers have participated in field experiments, which measured their ability to see objects on the road under varying levels of street lighting and glare from on-coming vehicles. This effort is expected to validate new lighting design standards.

The results of these studies and other research will be incorporated into the *Manual of Uniform Traffic Control Devices, the Highway Lighting Handbook*, and other documents used in highway design.

FEDERAL TRANSIT ADMINISTRATION

The Federal Transit Administration and the U.S. Administration on Aging began working together in 2002 to assist our respective networks in the coordination of transportation services for older adults and to facilitate access to these services by older adults and entered into a Memorandum of Understanding (MOU) on January 9, 2003. The two administrations have developed initiatives that are targeted to make it easier for local transportation providers to

serve older adults and help them remain independent and participating in their communities. We have focused on developing common sense transportation solutions as the key to promoting independence and opportunity for older adults. The key objectives of the MOU are focused in five areas: 1) Public awareness and outreach; 2) Data collection and promising practices; 3) Technical assistance to States and local communities; 4) Stakeholder input; and 5) Local and State transportation plan development.

In FY 2002, the National Easter Seal Society's Project Action hosted a National Dialogue on Accessible Transportation, which brought together representatives from the disability, transportation and human services communities to jointly pursue solutions to the unmet transportation needs of people with disabilities and older adults. An action plan was prepared and presents a number of recommendations and specific steps that can be taken in the pursuit of this agenda. Some of the on-going recommendations include: continue/expand the National Dialogue meetings on Accessible Transportation; integrate accessible transportation issues into existing grassroots community agendas; and publicize the availability of transit resource centers to the general public. Over the past few years Project Action has worked with a number of aging organizations in addressing accessible public transportation. Among the more than 100 products available free of charge from its clearinghouse are three publications that specifically focus on seniors and public transportation.

Through the Transit Cooperative Research Program, FTA sponsored the research project begun in fiscal year 1999, "Improving Public Transit Options for Older Persons." This project examined the population of interest in detail and identified barriers to mobility and methods to overcome them; detailed best practices from transportation programs designed to improve transportation opportunities for older persons; and identified further innovations. The final report was issued in 2002. The report describes exemplary transportation services and innovative transportation alternatives designed to enable older persons to maintain independence.

NATIONAL HIGHWAY TRAFFIC ADMINISTRATION (NHTSA)

Vehicle Design for Crash Avoidance.—NHTSA's crash avoidance research program addresses the relationship between vehicle design and driver performance and behavior. Emerging vehicle technologies could help reduce older driver crashes and enhance their mobility. For example, voice turn-by-turn in-vehicle navigation systems may allow drivers to concentrate on watching for dangerous traffic conflicts instead of being distracted while searching for road signs. Similarly, collision-warning systems would alert drivers to potential crash situations. In this area, NHTSA continues development of crash warning systems for rear-end crashes, lane change crashes, road departure crashes, and intersection crashes. Other developments in driver interfaces could provide technology-based innovations that would help older, functionally less able people continue to drive by offering all drivers much wider adaptability to unique personal needs, say through programmable "glass dash" options where older drivers could improve contrast and font size programming rather than settling for current fixed-configuration de-

signs, and could even control the nature of the information that is passed to them from the vehicle. NHTSA's research focus is thus to determine how the design and function of vehicle systems could/should be adapted to better meet the needs of all drivers, including the unique capabilities and needs of older drivers.

Pedestrian Safety Issues.—Older pedestrians, 65 and over, account for a smaller proportion (7.7 percent) of all pedestrian crashes than would be expected by their numbers in the population (12.8 percent). However, they account for more than one in five (22.4 percent) of pedestrian fatalities. In response to this problem, NHTSA and FHWA are continuing work aimed at preventing crashes involving pedestrians. In 2002, an analysis of pedestrian crash data from the previous five years was initiated. Based on these projects as well as public information projects, NHTSA participated in a forum to develop strategies on active aging that was sponsored by the Robert Wood Johnson Foundation in October 2002.

Older Driver Safety.—The majority of older drivers do not constitute a major safety problem. Research has indicated that most older drivers adjust their driving practices to compensate for declining capabilities. They reduce or stop driving after dark or in bad weather and avoid rush hours and unfamiliar routes. There are, however, individuals who are at increased risk for crashes or who may not adequately change their driving habits. NHTSA is hard at work trying to identify those drivers through its research program and to make tools and information available to people who interact with them so that drivers will make better decisions. In 2001, NHTSA entered into an Inter-Agency Agreement with the National Institute on Aging to identify the specific needs of caregivers for Alzheimer's disease patients. Also released that year, *Family and Friends Concerned About an Older Driver* identifies the information needs of the more general population of caregivers and provides direction to NHTSA and others who will fill those needs. Based on this research, a series of three web-seminars was developed with the American Society on Aging (ASA) to provide information to aging-network professionals. These seminars will be repeated in the Fall of 2003.

In 2001, NHTSA released an analysis of the Utah Crash Outcome Data Evaluation System (CODES), *Further Analysis of Drivers Licensed With Medical Conditions in Utah.* This report followed an earlier study on the topic, but focused on crash involvement of individuals with different levels of license restrictions based on the severity of their medical conditions.

In addition to conducting research in this area, NHTSA participated in the November 1999 Transportation Research Board (TRB) conference on Transportation in an Aging Society: A Decade of Experience. Participants at this conference identified research gaps in the knowledge base regarding older road users. In August 2001, NHTSA released a research plan for studies from that conference that fall under NHTSA's mission. Based on the problem statements identified in that report, two studies were initiated regarding polypharmacy, or multiple medications and their effects on driving. In the first study, a research design was developed for testing the effects of multiple medications on older drivers in a simulator. This internal project identified the challenges and safety issues sur-

rounding research of that nature. A second project that was started in August 2002 is investigating the crash involvement rates of individuals over age 50 who have been prescribed medications, with particular emphasis on multiple medications. The contractor is examining a proprietary insurance database to determine what combinations of medications are most problematic.

Because of a recognized gap in program activities, in September 2002, NHTSA began gathering information for a compendium of older driver programs that are operated through law enforcement agencies nationwide. Programs typically fall into three categories: officer training; officers training seniors; and, community partnerships to promote safety.

Driver Assessment Activities.—Unsafe older drivers are not easily detected with standard licensing procedures. Further, there is some doubt as to whether most licensing staff have the skills necessary to detect problem drivers, even with training and state-of-the art testing techniques. Diagnostic tests currently in use have not been shown to be effective in identifying those older drivers who are at increased crash risk, but some tests of "speed of attention" and "visual perception" may have such potential, particularly at detecting the cognitively impaired. A study in the State of Maryland that was completed in 2002 promises to reveal which of these tests is most predictive of crash involvement. In addition, a project with the State of Florida aims to better identify and counsel cognitively impaired drivers. NHTSA is also investigating the degree to which rehabilitation is an option for drivers with certain medical conditions. The goal is to keep people driving for as long as it is safe for them to do so. In 2002, NHTSA and the American Occupational Therapy Association began a cooperative agreement that is designed to increase the numbers of occupational therapists who have training in older driver assessment or rehabilitation. A small expert panel was held in December 2002 to identify strategies for increasing the ranks of individuals with these skills.

RESEARCH AND SPECIAL PROGRAMS ADMINISTRATION (RSPA)

RSPA's Volpe National Transportation Systems Center researches issues related to aging drivers through its Operator Performance and Safety Analysis Division. The division resolves problems across all transportation modes by performing research to analyze the relationship between human behavior and transportation safety and productivity. The division has an on-site laboratory, the Center for Human Factors Research in Transportation, operated collaboratively with the Massachusetts Institute of Technology (MIT). More information on aging-related research may be found at: http://www.volpe.dot.gov/opsad/index.html.

RSPA manages the Department's University Transportation Centers (UTC) Program (http://utc.dot.gov/). Each center focuses its research on a specific theme or interest area. Several of the Centers conduct research linked to improving mobility for elderly citizens.

The most significant research related to this topic is conducted at the Center for Transportation and Logistics at the Massachusetts Institute of Technology. Through MIT's AgeLab, the Center conducts research on the mobility needs of an aging populace and seeks to develop products to promote healthy independent living.

More information on the Center may be found at http://web.mit.edu/ctl/www/research/research.html, and on the AgeLab website at http://web.mit.edu/agelab/.

To a lesser extent, research on the impacts of an aging population on transportation systems and demand are conducted at several other UTCs. Further information on these Centers may be found as noted below:

University Transportation Center (UTC)	For Further Information
University Transportation Research Center City University of New York	http://www.utrc2.org/
National Transportation Center Morgan State University	http://www.eng.morgan.edu/ntc/
Southwest Region University Transportation Center Texas A&M University	http://swutc.tamu.edu/
National Center for Transportation Research University of South Florida	http://www.nctr.usf.edu/

Searches for UTC research reports on this and other topics may be conducted through the UTC search engine at: http://utc.dot.gov/results.html.

INFORMATION DISSEMINATION

FEDERAL HIGHWAY ADMINISTRATION

A one-day workshop was developed to familiarize traffic engineers and highway designers with the *Older Driver Highway Design Handbook*. The workshop covers the needs and capabilities of older road users, reviews the recommendations of the Handbook in detail, and presents case studies as learning exercises. It was designed for federal, state, and local highway designers, traffic engineers, and transportation professionals. To date, over 95 workshops have been held in over 40 states, training approximately 2,500 traffic engineers. FHWA personnel from across the country have attended "train the trainer" sessions, thereby allowing FHWA to better meet the numerous requests for workshops. The workshop was revised to reflect information contained in the new edition of the Handbook that was published in 2001 entitled *Highway Design Handbook for Older Drivers and Pedestrians.*

In 1999, the FHWA established the Pedestrian and Bicycle Information Center (PBIC) to provide technical assistance to localities on accommodating pedestrians, including older pedestrians. The PBIC is operated by the Highway Safety Research Center of the University of North Carolina, and offers a website (www.walkinginfo.org), an 800 number (877–925–5245), fact sheets and expert assistance. The PBIC enhances the effectiveness of the USDOT by providing additional technical expertise to individuals with questions about pedestrian and bicycle facilities and programs.

As an implementing agency for the Americans With Disabilities Act (ADA), FHWA published a guideline *Designing Sidewalks and Trails for Access—A Review of Existing Guidelines and Practices—Part 1.* A Best Practices Guidebook was released in September 2001. This document explains the needs of pedestrians with disabilities, including the needs of older pedestrians, and provides guidance on how to design universally accessible pedestrian facilities. FHWA also initiated a project in 2000 focusing on Intelligent Transportation Systems-based pedestrian countermeasures, including some technologies (infra-red detection) that will benefit older

pedestrians. Older pedestrian issues are included in all ongoing FHWA outreach activities, including the Intersection Hazard Index for Pedestrians and Bicyclists, and the University Pedestrian/Bicyclist Graduate Course, as well as other active work with State DOTs and other transportation agencies.

FEDERAL RAILROAD ADMINISTRATION

Information about Amtrak accessibility is available to senior citizens and passengers with disabilities in a brochure entitled "Access Amtrak" which can be obtained by calling 1–800–USA–RAIL or ordering from the Amtrak website at www.amtrak.com. Amtrak also works directly with a number of organizations each year on moving groups of passengers needing assistance and traveling together.

NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION

A broad array of public information materials and resources were introduced in 2001 and 2002. Through partnerships with outside organizations and within DOT, NHTSA has been able to expand its outreach efforts and reach new audiences. One product of that cooperation, a booklet called *Creating Communities for Active Aging*, is a guide to developing a strategic plan within a community to promote bicycling and walking. It was produced with the Partnership for Prevention. Another booklet on senior pedestrian safety was initiated in 2001.

Because data at the time indicated that African-Americans have lower seat-belt use rates than the general population, NHTSA determined that addressing this safety problem was critically important. Materials aimed at African-American seniors were developed in 2002. Safety information on vision, reflexes, and cognition are included in the booklet.

In 2001, an array of activities was initiated that focused on health care providers, both as recipients of information and as messengers. To capitalize on the success of the Emergency Nurses Association (ENA) TAKE CARE program, which uses nurses to train seniors on medication safety, NHTSA and ENA developed a module on driving safety. Emergency nurses now use this module to educate groups of seniors at public speaking events. The American Academy of Family Physicians and NHTSA conducted focus groups with physicians to determine the appropriate formats for materials regarding older driver safety. This information was used in a project with the American Medical Association (AMA). NHTSA and AMA have developed a physician's guide on medical conditions and how they relate to older driver safety. It also provides guidance on other assessments or referrals that might be appropriate. Another medical organization that NHTSA partnered with is the American Optometric Association (AOA). This partnership created a training workshop for practicing optometrists regarding older drivers and vision. NHTSA and AOA also initiated a partnership to develop patient materials regarding safe driving and eye diseases such as glaucoma and macular degeneration. Additional materials are under development which address other medical conditions that affect driving as we age: diabetes, stroke, Alzheimer's Disease, Parkinson's, arthritis, seizures, sleep apnea and sedating medications. A total of 11 such brochures are planned.

In addition, NHTSA is currently testing a kit of materials designed to assist aging professionals advise and counsel their older clients about driving safety. The kit is being tested in 5 demonstration sites around the country, with plans to distribute nationally after the demonstration phase is completed.

NHTSA is also piloting a social marketing campaign in another 5 sites that is designed to improve older driver safety by initiating local and family conversations about driving safety. In many communities in America older drivers feel compelled to keep driving even after they become concerned about their declining skills because there are simply no alternatives available. The pilot seeks to involve local community leaders to ensure that transportation and other services are available so that older drivers may gradually begin to "retire" from driving when the need arises.

RESEARCH AND SPECIAL PROGRAMS ADMINISTRATION

The University Transportation Centers (UTC) Program integrates its products in a directory of University Research Results at: http://utc.dot.gov/results.html. The directory includes the title of each report and a contact that can provide further information on the research and the availability of documentation.

Research results and other activities at RSPA's Volpe National Transportation Systems Center may be accessed at: http://www.volpe.dot.gov/ourwork/index.html.

Results from UTC and Volpe programs may be found in the Transportation Research Information Services (TRIS) on-line database, operated jointly by the National Research Council's Transportation Research Board, and the Bureau of Transportation Statistics' National Transportation Library, at: http://199.79.179.82/sundev/search.cfm.

ITEM 12—DEPARTMENT OF THE TREASURY

7U.S. TREASURY ACTIVITIES IN 2001–2002 AFFECTING OLDER AMERICANS

The Treasury Department recognizes the importance and the special concerns of older Americans.

SOCIAL SECURITY TRUST FUNDS

The Secretary of the Treasury is the Managing Trustee of the two Social Security Trust Funds (Old-Age and Survivors Insurance and Disability Insurance). The Trustees issue an annual report on the short- and long-run financial status of these trust funds. In the March 2003 report, covering calendar year 2003, the Trustees projected that full benefits can be paid for about the next 39 years, one year longer than in the 2002 report. A higher assumed rate of immigration contributed to the solvency of the trust funds. The 75-year actuarial deficit of the Social Security program in the 2003 report is estimated to be 1.92 percent of taxable payroll compared to 1.87 percent in the 2002 report. The OASDI Trustees' Report is available at www.ssa.gov/OACT/TR/index.html.

There was an automatic 2.6 percent benefit increase in December 2001, and an additional 1.4 percent in December 2002. The taxable wage base was increased to $80,400 in 2001, $84,900 in 2002, and is $87,000 in 2003.

MEDICARE TRUST FUNDS

The Secretary of the Treasury is the Managing Trustee of the Federal Hospital Insurance (HI) and Federal Supplementary Medical Insurance (SMI) Trust Funds. In their March 2003 report, covering calendar year 2002, the Trustees projected that the HI Trust Fund will be exhausted in 2026, compared to 2030 in the 2002 report. In the 2003 report the 75-year HI actuarial deficit is projected to be 2.40 percent of taxable payroll, compared to 2.02 percent in the 2002 report. The SMI Trust Fund is projected to remain adequately funded into the indefinite future because its funding, by law, comes almost entirely from general revenues and premium payments. The Medicare Trustees' Reports are available at www.cms.hhs.gov/publications/trusteesreport.

PENSION AND RETIREMENT INITIATIVES

Defined Contribution Plan Retirement Security Initiatives

In February 2002 the Administration convened a Retirement Security Task Force in the wake of Enron Corporation's bankruptcy. Many Enron employees suffered substantial 401(k) retirement fund losses when the company stock in which they had invested for retirement became worthless. The task force included policy officials

from the Treasury, Labor, and Commerce Departments as well as the National Economic Council. The Task Force examined defined contribution system rules to determine how they might be changed to improve employees' and retirees' retirement security without imposing unreasonable increases in administrative burden on sponsors or otherwise reducing employer incentives to continue operating these plans. Defined contribution plans, operated on a solely voluntary basis by employers, are an increasingly important part of workers' retirement income.

The Task Force outlined four areas in which the defined contribution pension system could be improved: increasing diversification rights for 401(k) investors, providing timely information about 401(k) plan investments, notifying workers and retirees of blackout periods and restricting management trading of company shares during such periods, and lifting restrictions that prevent firms from providing investment advice to employees through third parties.

The Sarbanes-Oxley Act of 2002, signed into law in July 2002, addresses the Task Force recommendation on blackout periods. Provisions in the act require employers to provide 30-day notice to plan participants of an impending blackout period. (Blackout periods are defined as periods of three or more consecutive business days in which the ability of a participant to direct or diversify assets, or to obtain loans or distributions is affected.) In addition, directors or executive officers may not trade company stock acquired as compensation during a blackout that affects more than 50 percent of all participants.

Administration endorsed legislation addressing the three other Task Force recommendations was passed by the House of Representatives in 2002 and reintroduced in February 2003 as H.R. 1000, the Pension Security Act of 2003, which passed on April 14, 2003. The Senate has yet to act on the bill.

Provisions of H.R. 1000 allow participants to sell employer stock acquired in the form of matching contributions under one of two methods chosen by the employer. The first method allows for the sale of such stock by any employee who has participated in the plan for three years. The second allows any employee to sell shares of such stock three years after acquiring it.

H.R. 1000 also allows employers to provide investment advice to plan participants through third party fiduciary advisers, including plan administrators. If plan administrators provide advice, then certain disclosures concerning potential conflicts of interest must be made to participants.

Lastly, H.R. 1000 requires that employers provide quarterly statements for individual account plans reporting the participant's accrued and nonforfeitable (vested) benefits. The statement would also include the value of investments, reporting employer securities separately (a reminder of the importance of diversification), and a warning against holding more than 25 percent of one's assets in any single security.

Defined Benefit Plan Retirement Security Initiatives

The Treasury Department is involved in an initiative to reform defined benefit pension plan rules. This plan is being developed in conjunction with policy officials at the Departments of Labor and

Commerce as well as the National Economic Council and the Pension Benefit Guaranty Corporation, which insures the benefits of most participants in tax qualified defined benefit plans. Treasury Under Secretary for Domestic Finance Peter R. Fisher announced this initiative in his July 15, 2003 testimony before the House of Representatives Subcommittee on Select Revenue Measures of the Committee on Ways and Means, and the Subcommittee on Employer-Employee Relations of the Committee on Education and the Workforce. The objectives of the initiative are to increase the measurement accuracy of pension assets and liabilities, increase disclosures of plans' financial status to participants and the funding positions of pension plans, and to ensure the long run solvency of the government's pension insurance system.

First, the Administration recommends that pension liabilities be computed using a corporate bond yield curve rather than a rate based on the 30-year Treasury bond as required under current law. Use of a yield curve would explicitly recognize the time structure of each pension plan's future benefit payments resulting in liability calculations that are more accurate than any calculation based on a single discount rate. Accurate liability measurement must be the first step in any process that would improve pension plan funding.

Second, the Administration recommends that all plan participants, not just those covered by certain financially distressed plans, be informed annually of the value of their plans' assets and liabilities. Information on assets and liability values of certain underfunded plans would be made public. These increased disclosure requirements would provide better incentives for plan sponsors to fully fund their plans, participants with important information to use in bargaining for pension benefit and salary increases, and investors with information on the demands that a firm's defined benefit plan is likely to place on future sponsor income and cash flow.

Third, the Administration recommends that benefit growth be restricted in pension plans that are underfunded and whose sponsors are financially distressed. Under the Administration's proposal, if a plan sponsored by a firm with a below investment grade credit rating has a funding ratio below 50 percent of termination liability, benefit improvements would be prohibited, the plan would be frozen (no accruals resulting from additional service, age or salary growth), and lump sum payments would be prohibited unless the employer contributes cash or provides security to fully fund these added benefits. If a sponsor is undergoing bankruptcy the same restrictions would apply. In addition, the PBGC's guaranty limit would be fixed as of the date the plan sponsor files for bankruptcy.

Finally, the Administration has undertaken a review of defined benefit pension funding rules and is developing a plan for fundamental reform.

TAX POLICY

Income Tax

Each year, the width of the income tax brackets and the personal exemption and standard deduction amounts are increased to reflect the effects of inflation during the preceding year.

The personal exemption allowed for each taxpayer and dependent increased from $2,800 in 2000 to $2,900 in 2001 and to $3,000 in 2002.

Taxpayers age 65 or over (and taxpayers who are blind) are entitled to larger standard deductions than other taxpayers. Each single taxpayer who is at least 65 years old was entitled to an extra standard deduction of $1,100 in 2000 and 2001, and $1,150 in 2002. Each married taxpayer age 65 or over was entitled to an extra standard deduction of $850 in 2000 and $900 in 2001 and 2002. Thus, married couples both of whom were at least age 65 were entitled to an extra standard deduction of $1,700 in 2000 and $1,800 in 2001 and 2002. Including the extra standard deduction amounts and the basic standard deduction amounts, taxpayers age 65 and over were entitled to the following standard deductions for tax years 2000 through 2002.

Filing Status	2000	2001	2002
Single	$5,500	$5,650	$5,850
Unmarried Head of Household	$7,550	$7,750	$8,050
Married Filing Jointly:			
One spouse age 65 or older	$8,200	$8,500	$8,750
Both spouses age 65 or older	$9,050	$9,400	$9,650

The tax credit for the elderly (and permanently disabled) was retained throughout the period.

In addition to the changes from these adjustments for inflation, significant changes were enacted as the result of initiatives from President Bush in 2001 and 2003. Changes enacted in the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) affected years beginning in 2001, and changes in the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA), many of which accelerated phased-in tax reductions enacted in EGTRRA, affected 2003 and will affect 2004.

EGTRRA created a new 10-percent tax rate bracket beginning for 2002 that applied to the first $6,000 of taxable income for taxpayers with single filing status and the first $12,000 of taxable income for married taxpayers. For 2001, in lieu of the 10-percent tax bracket, taxpayers received an equivalent benefit through a rate reduction tax credit of 5 percent of the first $6,000 of taxable income for single taxpayers and the first $12,000 of taxable income for married taxpayers. Many taxpayers received the benefit of the credit through advance payment checks sent out in the summer of 2001 on the basis of information on 2000 tax returns. EGTRRA also reduced all tax rates in tax brackets above the 15-percent tax bracket. Each tax rate of more than 15 percent was reduced by 0.5 percentage point for 2001 and by one percentage point for 2002. The former 28-percent tax bracket was reduced to 27.5 percent for 2001 and to 27 percent for 2002. The 31-percent tax bracket was reduced to 30.5 percent for 2001 and to 30 percent for 2002. The 36-percent tax bracket was reduced to 35.5 percent for 2001 and to 35 percent for 2002. The former 39.6-percent tax bracket was reduced to 39.1 percent for 2001 and to 38.6 percent for 2002.

JGTRRA provided additional tax relief for 2003 and 2004. The reductions in tax rates higher than 15 percent previously scheduled to take effect in 2004 and 2006 were made effective immediately.

Tax rates in effect in 2002 were reduced from 27 percent to 25 percent, 30 percent to 28 percent, 35 percent to 33 percent, and from 38.6 percent to 35 percent, respectively. The 10-percent tax bracket was widened by $1,000 (to $7,000) for single taxpayers and by $2,000 (to $14,000) for married taxpayers. Tax rates were lowered on long-term capital gains and on dividend income. For dividends or capital gains that would have been taxable at a 10-percent or 15-percent marginal tax rate if they were ordinary income, the applicable tax rate was reduced to 5 percent. Otherwise, the applicable tax rate was reduced to 15 percent. Also, marriage penalty relief was provided for married taxpayers by increasing the standard deduction amount for married taxpayers to twice the amount for single taxpayers and by increasing the top of the 15-percent tax bracket for married taxpayers to twice the level for single taxpayers.

Under current law, the 10-percent bracket revision, the reductions in tax rates higher than 15 percent, and the marriage penalty provisions of JGTRRA will expire after 2004, and the capital gains and dividends provisions will expire after 2008. The provisions of EGTRRA described above will expire after 2010.

Under the Trade Adjustment Assistance Reform Act of 2002, a refundable tax credit is provided to eligible individuals for the cost of qualified health coverage. The credit is equal to 65 percent of the amount paid by certain individuals between the ages of 55 and 64 who are receiving pension benefits from the Pension Benefit Guaranty Corporation as well as certain other individuals.

The Administration has proposed an above-the-line deduction for the purchase of qualified long-term care insurance. Under the proposal, the deduction would be available for individuals that purchase long-term care insurance and for the employee's share of the cost of employer-provided coverage if the employee pays at least 50 percent of the cost.

The Administration has also proposed that an additional personal exemption be provided to caregivers who provide care in their homes for qualified family members with long-term care needs. Qualified family members would include the taxpayer's spouse, parent, or grandparent. To qualify, the family member must be a member of the taxpayer's household for the entire year. Under the proposal, an individual would be considered to have long-term care needs if he or she were certified by a licensed physician as unable to perform at least two activities of daily living without substantive assistance from another individual for at least 180 consecutive days. Alternatively, an individual would be considered to have long-term care needs if he or she (1) required substantial supervision to be protected from threats to his or her own health and safety due to cognitive impairment and (2) was unable to perform at least one activity of daily living or was unable to engage in age appropriate activities.

Estate and Gift Tax

The estate, gift and generation skipping transfer (GST) taxes form a unified system of taxes on the transfer of property. Taxpayers are allowed a unified credit that exempts the first $1 million of total transfers from tax in 2002 and 2003. Deductions are

allowed for debts, marital and charitable bequests, and certain other items. There are special provisions designed to ease the burden of the estate tax on family-owned farms and businesses. After accounting for the unified credit, transfer tax rates range from 41 to 49 percent.

The Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) included substantial changes to the transfer tax system. Under prior law, the amount exempt from transfer tax in 2001 was $675,000. This was scheduled to increase to $700,000 for 2002 and 2003, $850,000 for 2004, $950,000 in 2005 and $1 million for persons dying in 2006. After accounting for the unified credit, transfer tax rates for 2001 ranged from 18 to 60 percent. EGTRRA increased the exempt amount to $1 million for 2002 and 2003, $1.5 million for 2004 and 2005, $2 million for 2006 through 2008 and $3.5 million in 2009. EGTRRA reduced the top transfer tax rate to 50 percent in 2002. The top rate is further reduced by one percentage point per year from 2003 though 2007 (when it reaches 45 percent). In 2010, the estate and GST taxes are repealed. The gift tax is retained with a lifetime exemption of $1 million and tax rate of 35 percent.

For capital gains tax purposes, the basis of property acquired from a decedent is equal to the value of the property at the date of death. After repeal of the estate tax, property acquired from a decedent will receive the lesser of fair market value or the decedent's basis. Additions to basis will be allowed so that in general, estates that are not currently subject to estate tax will not be subject to capital gains tax in the hands of the heirs.

After 2010, all of the transfer tax provisions enacted as part of the EGTRRA will expire. Thus, under current law, estate tax repeal and the carryover basis regime will be effective for only one year, after which the estate tax as it was under pre-EGTRRA law will return. The exempt amount will be $1 million and the highest marginal tax rate will be 60 percent.

Retirement and Healthcare

The establishment and continued maintenance of retirement plans is of benefit to older Americans. The IRS and Treasury have issued guidance to assist employers in establishing and maintaining these plans and for plan participants to understand the rules regarding these plans. Guidance projects that directly impact older Americans include publications that provide information on the catch-up contribution, which allows plan participants who are age 50 or older to make an additional contribution to their 401(k), 403(b) or 457 plans, and issuance of regulations making it simpler for those over age 70½ to understand their obligations with regard to required minimum distributions from IRAs and other retirement plans. Treasury also began a project to address questions raised regarding "phased retirement," i.e., arrangements under which older Americans seek to begin pension payments as part of a plan to reduce hours worked.

With regard to healthcare, Treasury has issued guidance explaining the tax rules surrounding health reimbursement arrangements (HRAs). By issuing this guidance, Treasury believes that employers may be more likely to offer these arrangements to their employees

and retirees. The HRA can be used by employers to provide payments for health expenses (including insurance) to retirees.

EMPLOYEE ASSISTANCE

As part of a comprehensive family-friendly Employee Assistance Program, the Department's bureaus support eldercare programs. Eldercare programs provide information on resources available to Treasury employees who care for elderly parents, spouses, or other family members. To help relieve what can be a burden for employees, the program helps Treasury employees identify needed eldercare services ranging from "daycare" for older persons to specialized medical attention. In addition to the Employee Assistance Program, Treasury makes available to its employees various human resources (HR) flexibilities such as alternative work schedules, leave transfer programs, and telework programs. This support demonstrates Treasury's commitment as a progressive and family-friendly employer. The Employee Assistance Program also reduces absenteeism and anxiety which employees may experience from caring for an elderly family member, thus enhancing their productivity and benefiting the Treasury Department.

BUREAU OF ENGRAVING AND PRINTING

Tours and Exhibits

The tours at the Bureau of Engraving and Printing's Washington, DC facility are accessible to the widest variety of visitors' possible. We aim to make the tour experience accessible to everyone, from international visitors to those with disabilities. Our main tour entrance is constructed with a ramp so that individuals in wheelchairs or with difficulty walking can easily enter the building. We also provide free wheelchairs upon request for individual use within the building.

The galleries are accessible through the use of elevators for those visitors that cannot ascend or descend using the escalators. Our galleries are also equipped with television monitors that can present information identical to that given by the tour guides. These video programs are all subtitled to enhance the conveyance of tour information. The video programs are also available in a variety of foreign languages. The tour staff itself includes speakers of various languages including an American Sign Language Interpreter.

There is a medical facility in the building as well to provide emergency services to visitors should that service be required. We aim to make the building and tour accessible and understandable to everyone and believe we can meet the needs of those who require extra attention and assistance.

The tour and VC facility at the Western Currency Facility will include exhibits and displays that meet all ADA requirements upon it's completion in April 2004. Transportation vehicles will meet all local, state and Federal certifications, be ADA compliant and will be approved by the government prior to their use. In addition to all video and multimedia products, the Architectural and Transportation Barriers Compliance Board mandates that all multimedia

presentations which support the agency's mission that contain speech or other audio information shall be closed captioned.

Currency

The National Academy of Sciences conducted a study on ways to assist the blind and visually impaired with currency transactions. Based upon the recommendations of the study, the Bureau of Engraving and Printing (BEP) redesigned $5, $10, $20, $50 and $100 Federal Reserve notes with several features to assist the elderly and visually impaired.

In addition to several counterfeit deterrent features, the notes contain a large high-contrast numeral on the back, lower right corner. The large high-contrast numeral is designed to assist the more than 23 million Americans, mostly elderly, with varying degrees of vision impairment.

With the introduction of the newly redesigned Series 2004 $20 Federal Reserve note on October 9, 2003, the new notes now contain the addition of denomination-specific subtle background colors and symbols of freedom. In the case of the $20 note, the background colors are green, peach and blue, and the symbols of freedom are a large blue eagle and a small metallic green eagle and shield. These new features will help everyone, particularly those who are visually impaired and the elderly, to tell denominations apart.

BUREAU OF THE PUBLIC DEBT

TreasuryDirect

Public Debt launched its new TreasuryDirect system in October 2002. TreasuryDirect is an account-based system that currently offers paperless Series I and Series EE savings bonds. Customers establish an account and buy, manage, and redeem their securities over the Internet. Older investors can continue to enjoy the security of investing in savings bonds without making a trip to a local financial institution to purchase or redeem their holdings. A TreasuryDirect account provides a complete record of the investor's electronic holdings in one place. Purchases and redemptions are made through ACH debits and credits from a savings or checking account at a financial institution designated by the customer. There are no paper bonds to keep track of; no worry about lost or misdirected bonds in the mail; and holdings are accessible in an emergency, not at the bottom of a drawer or some other forgotten location. In the coming years we will add features to TreasuryDirect with the ultimate goal of offering all the securities Treasury sells to the public in a single account accessed over the Internet.

Additional Toll Free Service Available to the Public

Public Debt expanded toll free access to information and service in April 2003. Each of the five Federal Reserve savings bond processing sites now provides a toll free number to all their customers. The toll free numbers help older investors by providing easy access to savings bond information such as current interest rates, redemption values of bonds, and general information about savings bonds.

They can also order redemption tables and various savings bond forms. In addition, a toll free number is available for customers holding marketable securities in our legacy book-entry system so they can access electronic services (purchase/reinvest securities, get account balances, or order statements), order forms, find out about auction results or upcoming auctions, or get general information. All voice menus for the toll free numbers were recorded with older investors in mind.

Training and Customer Service

All of our customer service employees are thoroughly and consistently trained to ensure investors are satisfied when they interact with Public Debt through the phone, web or mail. Employees receive special training on telephone etiquette, corresponding with customers by e-mail or postal mail, and how to meet the needs of the older investor.

Public Debt recently developed an e-learning module as a continuing effort to supplement, and in some cases replace, traditional classroom training. This type of training allows employees to set their own pace and review courses as needed while providing lasting benefits to both Public Debt and our customers.

Extended Operating Hours for Marketable Securities Electronic Services

Public Debt began offering extended operating hours in August 2003 to investors using our Electronic Services for Treasury bills, notes, and bonds. In the past, customers could use telephone and Internet services from 8:00 a.m. until 8:00 p.m. EST. Now the services are available from 8:00 a.m. until 12:00 midnight EST. This extension of hours gives customers more time to use the suite of services that can be accessed by telephone or over the Internet. Some of the services offered are purchase and reinvestment, change of address and ordering a statement of account. These extended hours benefit all investors including older Americans.

Continuous Improvement of Website

Public Debt regularly updates its web pages to reflect changes in its products and services, and to improve the presentation of information in a logical and easy to access manner. Public Debt is in the process of redesigning its investor oriented website, where product information and services are offered, to improve its clarity, quality and ease of use. This new site, like our present web site, will fully comply with Section 508 of the Rehabilitation Act Amendments of 1998 (regulations requiring web pages to be fully accessible to individuals with disabilities). Improving the website will streamline citizen-to-government communications and make it easier for customers to interact with Public Debt.

In the spring of 2003, Public Debt provided online, fillable versions of savings bond and marketable securities forms used by the public. Fillable forms are electronic forms that users can download and complete using their own computer thus eliminating the need for users to complete paper forms by hand. Because fillable forms result in better legibility, Public Debt can more accurately service its customers. As of September 2003, Public Debt of-

fers nearly 100 savings bond and marketable securities forms and brochures online. As part of this effort, Public Debt rewrote its forms and accompanying instructions to put them into plain language for ease of use by investors.

Matured Unredeemed Bonds and Treasury Hunt

Public Debt continues to work to increase investor awareness of savings bonds that are no longer earning interest. Since most of these bonds are at least 30 to 40 years old, many owners are senior citizens. Investors can use Public Debt's website to find out if they have any of these bonds by searching a database called Treasury Hunt; reviewing a general information page about whether bonds are still earning interest by the series and issue date; or, using the Savings Bond Wizard or Savings Bond Calculator to identify matured bonds. Also, through a special "locator group," Public Debt actively tries to find owners of matured unredeemed bonds to let them know they are no longer earning interest.

Treasury Hunt also helps the public identify other Treasury securities or interest payments that they may be due. This web-based application identifies securities information for an investor when:

- They own a savings bond and haven't received it in the mail.
- They have interest payments that we couldn't deliver.
- They own a registered Treasury note or bond that has matured and is no longer earning interest.
- They have not yet received their payments.

Customers can search the Treasury Hunt database 24 hours a day, 7 days a week.

FINANCIAL MANAGEMENT SERVICE

In FY 2002, the Financial Management Service (FMS) issued more than 918 million payments, including Social Security, Supplemental Security Income, Veterans benefits, and tax payments. Working under the mandate of the Debt Collection Improvement Act signed by President Clinton on April 26, 1996, Federal Departments and agencies are on the fast track to convert Federal payments to electronic funds transfer (EFT). The law required most payments to be made electronically by January 2, 1999, but also gave the Secretary of the Treasury broad authority to grant waivers. EFT significantly improves the certainty of payments reaching the intended recipients on a timely basis, and improves the ability of recipients to use those payments safely and conveniently. Payment inquiries and claims are significantly reduced under EFT.

Payment by EFT has substantial benefits in terms of reliability, safety, and security that are especially important for the elderly. Recipients are much more likely to have a problem with a paper check than with an EFT transaction, and in FY 2002 Treasury received more than 1.4 million inquiries from recipients regarding checks not received. In FY 2002, the Federal Government experienced more than $69.1 million in forged checks, $2.2 million in counterfeit checks, and $4.3 million in altered checks. Waiting days for a replacement check is an inconvenience and a burden on recipients, especially elderly persons living on low incomes. EFT payments are much more convenient and secure—misrouted EFT pay-

ments are never lost, and, if misrouted, the payments are typically routed to the correct bank account within 24 hours.

During the past six years, Treasury has been overseeing government-wide implementation of the Debt Collection Improvement Act of 1996 by working with Federal agencies to identify and resolve the major issues confronting stakeholders. Significant progress has been made by Federal agencies to convert payments to EFT. The percentage of Treasury-disbursed payments, including tax payments made electronically, has increased from 53 percent in FY 96 to 73 percent in FY 02. More than 79 percent of Social Security payments were made electronically in FY 02, an increase of more than 18 percentage points since FY 96. Other Federal benefit agencies show similar increases in EFT payments. Approximately 14 million Federal benefit checks are still issued on a monthly basis.

Federal payment recipients who elect to receive their payments via Direct Deposit enjoy the benefits of this simple, safe, and secure payment mechanism. Recipients who have not signed up for Direct Deposit do have choices, as described in 31 CFR 208. Federal check recipients receiving salary, wage, benefit or retirement payments can chose to: (1) receive payment via Direct Deposit through a financial institution, (2) open a low-cost Electronic Transfer Account (ETA℠) at a participating Federally insured financial institution, or (3) continue to receive a paper check, if receiving payment by Direct Deposit would cause the recipient a hardship.

In 1999 Treasury developed a basic, low-cost account called the ETA℠, which is available to individuals who receive Federal benefit, wage, salary, or retirement payments. Nearly 600 Federally insured financial institutions, at over 18,000 branch locations nationwide, offer the ETA℠ on a voluntary basis, subject to published standards and terms set forth in an agreement between Treasury and the financial institution. These low-cost accounts are designed to meet the statutory mandate that recipients have access to an account at a reasonable cost and with consumer protections, comparable to other accounts at the same financial institution. Anyone who receives a Federal benefit, wage, salary, or retirement payment is eligible to open an ETA℠, even if they have been unable to qualify for a checking or savings account in the past. The ETA℠ costs $3.00 a month or less and requires no minimum balance to open or maintain the account, except as required by law. As of July 2003, over 67,000 ETAs have been reported opened by financial institutions.

Although EFT participation has been increasing each year, the rate of EFT growth has slowed to about 1 percent a year and FMS is exploring ways to significantly increase the EFT participation rate among Federal benefit recipients. Therefore, FMS, in collaboration with the Federal Reserve Bank of St. Louis and the Social Security Administration, initiated a study to conduct research into the reasons why some Federal benefit recipients choose checks over electronic payments, and to explore what delivery options might best meet the needs of benefit recipients. The results of this research will be used to identify "motivational triggers" to participation in electronic payment programs and to develop effective communication strategies for the development of a marketing and edu-

cation campaign to entice current check recipients to convert to electronic forms of payment. It is anticipated that the results of the research will be available early in calendar year 2004.

A variety of information on EFT and Direct Deposit is available on the FMS website. Information available includes publications, statistics, and contact information. The EFT website also includes topics on General Information, Regulations and Policy, Agency Assistance, News and Media, Education and Marketing, Vendor Information, and the ETA℠. The site can be accessed at www.fms.treas.gov/eft.

The Check Forgery Insurance Fund

The Check Forgery Insurance Fund (CFIF) legislation was enacted into law on April 26, 1996, as part of the Debt Collection Improvement Act of 1996.

The CFIF is a revolving fund established to settle payee claims of non-receipt where the original check has been fraudulently negotiated. FMS uses the Fund to ensure those innocent payees whose Treasury Checks have been fraudulently negotiated are promptly issued replacement checks. Reinstitution of the CFIF relieves the burden for recipients of forged checks by providing funding for expeditious issuance of replacement checks.

Check forgery is a concern of FMS and individuals who receive paper check payments. FMS continues to consider and address this concern. On March 26, 1998, various Treasury Systems were enhanced to comply with the legislation and to modify both internal and external operational and system procedures required to process check forgery claims timelier, utilizing the CFIF. Reinstitution of the CFIF relieves the burden for recipients of forged checks, especially the elderly.

The CFIF is a Fund, which benefits all payees of forged checks after the forgery has been substantiated. Although payment by electronic funds transfer (EFT) has substantial benefits, paper checks continue to be the desired method of payment by recipients of various Federal payments. The elderly, who represent a large portion of this group, continue to receive payments by check. Because of continued check issuance, forgery of these items is highly probable. Those elderly individuals affected by forgeries are largely low-income, unbanked, and rely on the monthly payment for their basic subsistence. The CFIF allows for immediate relief to the elderly and other payees after the claim of forgery has been substantiated.

Implementation of the CFIF benefits the Federal Program Agencies (FPAs) by relieving the FPAs of the responsibility for issuing replacement checks out of their appropriations on forgery claims. Typically, the FPAs would not issue a replacement check on a forgery claim until after FMS had recovered the forged amount from the financial institution (FI) and credited the agency with the check amount. The FI has 60 days to respond to FMS' request for refund. The CFIF provides for expeditious processing of these cases and does not make issuance of the replacement check contingent on whether recovery on the forgery is delayed or unsuccessful.

FMS is continuing to use the CFIF to facilitate the timely issuance of replacement checks to the elderly and all check recipients on substantiated forgery claims.

Debt Collection Improvement Act

The Debt Collection Improvement Act of 1996 and the Taxpayer Relief Act of 1997 authorize the collection of delinquent debt through administrative offset and levy of Federal Payments, including Social Security benefits. Over the last several years, FMS has coordinated with the Internal Revenue Service and the Social Security Administration to collect $372 million annually in delinquent debt potentially available through levy and offset of benefit payments. FMS and SSA recently have agreed to begin phased in implementation of benefit payment offset in March 2001 and continuous tax levy in October 2001. Implementation will begin with the offset of Cycle EFT payments. The offset of Cycle Check payments and Third of the Month EFT and Check payments will be phased in following the Cycle EFT payments implementation. Supplemental Security Income payments are exempt from offset, as required by law. Old-Age Survivors and Disability Insurance benefit payments are offset internally by SSA.

Based upon a preliminary test conducted by FMS in 1998, the number of potential offsets of SSA benefits payments matched against the FMS Debtor Database showed 35,670 for the month of February. If this pattern were to continue for the year, approximately 429,120 benefit payments would be offset annually with collections for the Government between $36 million and $61 million. The amount of the offset of the Social Security benefit payment will be the lesser of 1) the amount of the debt, or 2) an amount equal to 15 percent of the monthly benefit payment, or 3) the amount, if any, by which the monthly benefit payment exceeds $750. Fifteen percent is the maximum amount that will be offset from an individual's benefit payment.

FMS will provide the debtor with a notice of the intent to offset and an opportunity to review the basis for the debt by notifying the debtor twice in writing at both a 60-day and a 30-day interval prior to the anticipated offset. The warning letters include the name of the agency that originated the debt and the name of a contact within that agency to answer questions regarding the delinquent debt. FMS will also send the debtor an offset notice that includes the amount and date of the offset in addition to the same information provided in the 60-day and 30-day warning letters. The offset notice is sent to the beneficiary to coincide with the timing of the prescheduled payment. The offset remains legal even if the debtor does not receive the notices.

In the case of payment levies to collect delinquent tax debt, IRS will send each tax debtor a notice that includes the tax bill, a statement of the intent to levy, an explanation of an individual's appeal rights, and an IRS telephone number for inquiries and assistance. The notice, which will be sent by certified mail to the taxpayer's last known address, will also inform the debtor that if repayment arrangements are made within 30 days, the levy will not occur. Also, IRS will send tax debtors who receive Social Security benefit payments an additional notice of intent to levy. At the time of the

levy, FMS will send a notice to the debtor explaining the reason for the reduced payment and giving a contact at IRS who will answer questions regarding the tax debt. At any time during this process, either prior to or after the levy process begins, a debtor may make repayment arrangements with IRS, which will then release the levy.

INTERNAL REVENUE SERVICE

Publications

The IRS recognizes the importance and special concerns of older Americans, a group that will comprise an increasing proportion of the population in the years ahead. The following publications, revised on an annual basis, are directed to older Americans. Each year, IRS reviews the publications to ensure that they are updated to reflect changes in tax law as well as to simplify the explanations in them.

Publication 524, "Credit for the Elderly or Disabled," explains that individuals 65 or older may be able to take the Credit for the Elderly or Disabled, reducing taxes owed. In addition, individuals under age 65 who retire with a permanent and total disability and receive taxable disability income from a public or private employer because of that disability may be eligible for the credit.

Publication 554, "Older Americans' Tax Guide," explains the income conditions under which single taxpayers aged 65 or older, and married taxpayers filing jointly if at least one spouse is 65 or older, are generally not required to file a Federal income tax return. The publication also advises older taxpayers about eligibility for the earned income credit. The taxpayer may be eligible for a credit based on the number of qualifying children in the home or a smaller credit if the taxpayer has no qualifying children. The Guide serves as a primary source of tax information for older Americans.

Publication 721, "Tax Guide to U.S. Civil Service Retirement Benefits," and Publication 575, "Pension and Annuity Income," provide information on the tax treatment of retirement income.

Publication 907, "Tax Highlights for Persons with Disabilities," is a guide to issues of particular interest to persons with disabilities and to taxpayers with disabled dependents.

Publication 915, "Social Security and Equivalent Railroad Retirement Benefits," assists taxpayers in determining the taxability, if any, of benefits received from Social Security and Tier 1 Railroad Retirement.

Publication 590, "Individual Retirement Arrangements (IRAs)," includes information about deductions and tax treatment of distributions for various retirement accounts.

All publications are available free of charge. They can be obtained by using the order forms found in the tax forms packages or by calling 1–800–TAX–FORM (1–800–829–3676). Many libraries and post offices stock frequently requested forms, schedules, instructions, and publications for taxpayers to pick up. Also, many libraries stock a reference set of IRS publications, and a set of reproducible tax forms, and may have access to the Internet to download tax materials.

Most forms and some publications are on CD–ROM and are on sale to the public through the National Technical Information Service on the Internet at www.irs.gov/cdorders, or by calling toll-free 1–877–CDFORMS (1–877–233–6767). Forms, instructions, and tax information are available by fax by calling (703) 368–9694, using a telephone connected to a fax machine.

Taxpayers may obtain most forms, instructions, publications, and other products via the IRS Internet website 24 hours a day, 7 days a week, at www.irs.gov.

The IRS has continued the availability of large-print versions of the Form 1040 and print versions of the Form 1040 and Form 1040A packages earmarked for older Americans. These packages (designated as Publication 1614 and 1615, respectively) are newspaper-size and contain both instructions and forms (for use only as worksheets, with the amounts to be transferred to regular-size forms for filing).

Finally, the IRS web site has several pages designed especially to address key concerns of the elderly. For example, the section for Individuals links taxpayers to information about the Tax Counseling for the Elderly (TCE) outreach program (see below for an overview of this program). A link is also provided there for retirees and senior citizens offering information about IRAs and pension plans.

Volunteer and Outreach Programs

Volunteer Income Tax Assistance Program

The Volunteer Income Tax Assistance (VITA) program has been offering FREE tax help to people who cannot afford to pay for professional assistance since the program was formed in 1969. VITA volunteers help prepare basic tax returns and answer simple tax questions at no cost for low- to moderate-income taxpayers, which often include persons with disabilities, limited English speaking and the elderly. Many sites offer FREE electronic filing. Volunteers from community organizations, colleges, professional organizations, religious organizations, military, retirement organizations as well as IRS employees participate in this program. Assistance is provided at or near community and neighborhood centers, libraries, schools, churches, shopping malls and other convenient locations across the nation.

In 2001, over 44,000 VITA volunteers at more than 8,500 sites assisted over 1.7 million taxpayers across the nation. For 2002, more than 1.7 million taxpayers received tax assistance from over 34,000 volunteers at approximately 5,200 VITA sites across the nation. Statistics for these two years included assistance other than tax preparation. In 2003, tax preparation alone exceeded 840,000 returns, prepared by more than 36,000 VITA volunteers, at over 4,000 sites.

Tax Counseling for the Elderly (TCE) Program

The Tax Counseling for the Elderly (TCE) Program offers FREE tax help to individuals who are age 60 or older. Congress first authorized the TCE Program in 1978 as part of the Revenue Act of 1978. The 1978 Act authorized IRS to enter into agreements with

private or non-governmental public non-profit agencies and organizations, exempt under Section 501 of the Internal Revenue Code, which would provide training and technical assistance to volunteers who provide FREE tax counseling and assistance to elderly individuals in preparing their Federal income tax returns.

The 1978 Act authorized an appropriation of special funds, in the form of grants, to provide tax assistance to persons age 60 years of age or older. Grant funds are used to reimburse volunteers for out-of-pocket expenses including transportation, meals and other expenses incurred by them in providing tax-counseling assistance at locations convenient to the taxpayers. In addition to volunteer out-of-pocket expenses, funds may be used by the sponsoring organization for salaries, wages, and benefits of clerical personnel; office supplies and equipment with a unit cost of less than $15; printing and postage costs; installation of telephone lines necessary to service a telephone answering site; rent, utilities, and custodial services when necessary; and costs for interpreter services.

In 2003, nearly 33,000 volunteers participated in the TCE Program at over 9,000 site locations across the nation, helping taxpayers successfully file nearly 800,000 paper and electronic returns.

Outreach Program

The Outreach Education Program provides individuals with information on a variety of tax topics. The IRS seeks to educate taxpayers on new tax law, available credits and other tax information that will assist them in filing a correct tax return. Outreach provides awareness of available deductions, credits, proper income reporting and other tax-related topics. Through the use of intermediaries and partners, targeted groups of taxpayers are provided with brochures, publications, bill inserts and other delivery methods to communicate information on topics of interest to that particular population. Partners who provide services to older Americans are called upon to provide messages to ensure related tax information is shared. Trained volunteers and IRS employees conduct tax related seminars for groups and individuals with common tax interests. For elderly taxpayers the IRS has focused on providing education around retirement issues and the Earned Income Tax Credit for those who may be raising second generation children in their home and other related tax issues.

For Tax Year 2001, over 681,000 taxpayers received assistance through the outreach program by over 1700 volunteers at more than 7600 sessions. For Tax Year 2002, more than 69 million taxpayers received educational information through the mail, media outlets, tax seminars, conventions, and community events. To date for Tax Year 2003, over 143 million taxpayers have been provided with educational information or attended seminars. More than 50,000 volunteers assisted taxpayers at over 18,000 outreach sessions. This tremendous increase was made possible by shifting the focus away from IRS employees providing the majority of direct outreach activities to establishing partnerships with community-based organizations, non-profit organizations, and other government agencies whose primary client base is similar to the audience

being targeted for outreach. Through this alliance the IRS has been successful in reaching many more taxpayers than in the past.

Major Changes in Programs and Policies

In October 2000, the IRS underwent a complete reorganization. This resulted in the creation of four new operating divisions developed to serve four distinct customer sets. The Wage and Investment (W&I) operating division serves approximately 122 million individual taxpayers who receive W–2 and investment income only. Almost 15 million W&I filers are over age 60. Within the W&I operating division is the pre-filing element that focuses on providing Taxpayers with the information, support and assistance they need in order to understand and fulfill their tax obligations. The Stakeholder Partnerships, Education and Communication (SPEC) function provides educational service through leveraged channels, such as community-based and non-profit organizations. This allows for delivery of tax-related materials and services to taxpayers who need assistance. Providing service and education to the elderly population is a key focus area for SPEC. Before the reorganization, a small department delivered outreach and education to a small number of taxpayers. The limited resources prevented a far-reaching initiative for large groups of taxpayers. Volunteer-sponsored programs have been in place for many years with enormous IRS support being provided to sustain them. The concept of operation within the SPEC function concentrates on establishing community and partner coalitions to provide much of the service previously offered by IRS employees. The elderly population is a taxpayer group that is targeted for tax-related education and free tax return preparation. Investment and pension income reporting requirements and credits available to the elderly are primary educational initiatives.

New Initiatives

For fiscal year (FY) 2003, the W&I organization, through its SPEC function, developed a business objective to increase awareness among older taxpayers of retirement issues to prevent balance due situations. SPEC used their partnership channels to provide information about the most common retirement-related issues that could potentially cause a balance due situation. SPEC will again address compliance issues for older Americans as part of their FY 2004 business objectives, targeting military retirees.

Banks, Post Offices and Library (BPOL) Program

During 2003, the BPOL program provided approximately 37,800 locations with free tax preparation materials such as tax forms and publications to assist in preparing Federal income tax returns. In some areas, IRS recruited volunteers who worked at libraries, answering tax questions and directing taxpayers to the appropriate tax forms.

OFFICE OF THE COMPTROLLER OF THE CURRENCY

During 2001 and 2002, the Office of the Comptroller of the Currency (OCC) continued to enforce fair lending laws relating to age discrimination. The OCC has also continued to emphasize evaluating the performance of national banks with respect to the Com-

munity Reinvestment Act (CRA). The OCC Compliance Division specifically focuses on consumer compliance, the CRA, and fair lending.

OCC examiners are alert to the potential for discrimination on the basis of age (as well as other bases covered by ECOA and Reg. B) when conducting fair lending examinations. During 2001 and 2002, the OCC found evidence of age discrimination during four fair lending examinations. Two of the cases were referred to the Department of Justice for action. All four cases were resolved through administrative or corrective action. The addition of the cases identified during 2001 and 2002 brings the total number of OCC cases involving age discrimination to fourteen since 1993.

During 2001 and 2002, Comptroller John D. Hawke, Jr., and First Senior Deputy Comptroller and Chief Counsel Julie L. Williams, met with representatives of 28 community and consumer organizations, including representatives from organizations that focus on issues dealing with aging and senior citizens such as the AARP. The OCC's Community Affairs division facilitated these meetings. The purpose of these outreach sessions was to learn firsthand about any concerns these organizations have about national banks and issues affecting bank customers, especially low- and moderate-income consumers, including predatory mortgage lending and payday lending practices, affordable housing, community reinvestment, and access to financial services for the unbanked. During 2001–02, the OCC also participated in an Interagency Predatory Lending Task Force, which drafted a brochure for consumers, "Putting Your Home on the Loan Line is Risky Business."

The OCC's Customer Assistance Group (CAG) is responsible for the review, analysis and processing of complaints lodged about national banks including affiliates of national banks. Many of the complaints received by CAG are submitted by older Americans. During 2001, the CAG handled over 79,000 telephone contacts resulting in 80,000 new cases. During 2002, the volume slightly decreased to 78,000 telephone contacts producing 79,000 new cases. The CAG maintains a toll-free national consumer hotline (1–800–613–6743) that is staffed with trained professionals, able to handle cases in languages other than English, providing callers with guidance and informal education on current banking laws, regulations and practices. Consumers may also avail themselves of CAG's services through the Internet (www.occ.treas.gov/customer.htm) and gain access to information about the OCC including its complaint resolution process.

OFFICE OF THRIFT SUPERVISION

The Office of Thrift Supervision (OTS), along with the other Federal banking agencies, continues to enforce fair lending laws relating to age discrimination. OTS implemented new fair lending examination procedures for all examinations conducted after 1999. During 2001–2002, OTS examiners used these procedures when conducting fair lending examinations to assure that OTS-regulated institutions are not discriminating on the basis of age in the credit decision-making process.

OTS has an active program for addressing complaints that consumers may have against the thrifts that OTS regulates. OTS pro-

vides a free nationwide consumer hotline (1–800–842–6929), a TDD line (1–800–917–2849), and an email address (consumer.complant@ots.treas.gov). Professional staff is available to help people evaluate whether OTS regulations address their concerns. Senior citizens are frequent users of this service.

OTS maintains a Customer Service Plan for consumer complaints and urges the institutions it regulates to give high priority to consumer relations. Over 20,000 complaints were filed with OTS in 2001 and 2002, 17 of which alleged credit discrimination based on age. In each case, the complaint was investigated, the complainant interviewed, and the complainant's loan file reviewed to determine appropriate resolution.

Each of OTS's four regional offices has staff responsible for community affairs matters. Community Affairs staff serve as liaisons between the thrift industry, consumer and community groups, government agencies and others on housing and community development issues; provide education and training to the thrift industry on community development issues; and identify opportunities for thrifts to partner with others in helping to meet financial services needs in their communities. OTS Community Affairs staff interacts with many groups representing low- and moderate-income individuals, including older persons.

In 2001 and 2002, Community Affairs staff, along with OTS senior management, participated in various forums with thrifts, community organizations and others across the country, including groups with particular emphasis on older persons. At these forums, OTS staff provided information on a number of topics such as reverse mortgages, banking needs of the elderly, predatory lending, and financial abuse of the elderly.

For example, Community Affairs staff worked with police departments, financial institutions, and others in 2001 to hold a series of community outreach workshops throughout the Hispanic community focusing on crime prevention and the benefits of banking. Many of the victims of armed robberies and thefts in the Hispanic community are elderly. During 2001–2002, OTS partnered with the California Community Partnership for the Prevention of Financial Abuse to produce a training video. The video is designed to help educate the financial services industry about financial abuse of the elderly. Information about the development of the video was shared with lenders in a series of workshops, roundtables, and one-on-one meetings. OTS continues to work with the partnership to expand the video's distribution.

OTS's Community Liaison newsletter highlights accomplishments in affordable housing and community development, many of which have benefited older Americans. In 2001, the Community Affairs staff published four newsletters that were distributed to all thrifts and to several hundred community and consumer organizations. One of the articles spotlighted the efforts of FLAG (Financial Institutions, Law Enforcement and Government), a non-partisan partnership committed to protecting the elderly and persons with disabilities from financial exploitation.

OTS hosted a thrift industry leadership conference for CEOs and directors of OTS-regulated institutions in April 2001. The conference focused on strategic planning for the future and developing

new market opportunities. One of the sessions focused on the aging baby boomer population, and ways that banks can better serve the housing, credit and financial services needs of this group.

OTS issued a CEO Letter in 2001 that provided interagency guidance to the thrift industry on subprime lending and predatory or abusive practices. Many low- and moderate-income elderly homeowners are vulnerable to predatory lending practices.

OTS's Office of the Ombudsman has taken an active role in directing seniors that contact OTS to other resources that can provide assistance with a variety of elder consumer concerns. Some of the issues the Ombudsman deals with frequently are problems with Social Security benefits, income tax preparation and assistance, information about cashing Treasury obligations, Thrift Savings Plan accounts, and accounts held at federally chartered financial institutions. OTS also works with state government Ombudsmen to refer consumers with concerns about assisted living and long-term care programs. The telephone number for the OTS Ombudsman is (202) 906–7945; more information is available at www.ots.treas.gov.

UNITED STATES MINT

The United States Mint continues to consider the needs and concerns of older Americans in its programs, activities, and operations.

Employee Retirement Planning

The United States Mint offers a variety of retirement planning courses and workshops for its employees. Several one- and two-day Civil Service Retirement System (CSRS) and Federal Employees Retirement System (FERS) training courses are open to Mint employees and as well as their spouses. The Mint also encourages its employees to use the resources available through the websites sponsored by the U.S. Office of Personnel Management and the Thrift Savings Plan. Links to these sites are located on the Mint's Intranet site.

Employee Assistance Programs

A full range of services provided by the Employee Assistance Program (EAP), managed by Federal Occupational Health, Department of Health and Human Services, is available to all Mint employees. Among these services are health, fitness, and nutritional information; psychological, family, and grief counseling; and time and stress management. Referrals for Elder Care service providers and legal assistance for the elderly are also available through EAP.

Employee Training

The Mint offers its employees a number of courses and workshops that provide the knowledge and skills needed to assist, effectively interact with, and be sensitive and responsive to the diverse needs of the aged and those with disabilities. Among these are courses on Equal Employment Opportunity Law and the Americans with Disabilities Act, and retirement training for HR professionals.

ITEM 13—CONSUMER PRODUCT SAFETY COMMISSION

REPORT ON ACTIVITIES TO IMPROVE SAFETY FOR OLDER CONSUMERS

Each year, according to estimates by the U.S. Consumer Product Safety Commission (CPSC), nearly 1.5 million people age 65 and older are treated in hospital emergency rooms for injuries associated with products they live with and use every day. In 2002, the death rate for older people was approximately four times that of the younger population for unintentional injuries in home settings. Specifically, there are 35 deaths per 100,000 persons 65 and older, while there are about eight deaths per 100,000 persons under 65. Older adults-those over 65 years of age-are the fastest growing segment of the U.S. population.

Hazards in the Home

- *Slips and Falls*:—Slips and falls are the main source of injury and death for older people in the home. In home settings in 2002, there were approximately 6,500 deaths to victims 65 and older (6,000 of these fatalities were to persons 75 and older). When older people fall, their risk of serious injury or death is much higher than that of the general population. Falls occur in the bathroom, especially in the bathtub and shower. Falls are also common on stairs, stepstools, and floors with loose carpets. CPSC recommends the use of grab-bars and non-slip mats by the bathtub and shower, handrails on both sides of the stairs, and slip-resistant carpets and rugs. CPSC worked with industry to develop requirements for slip-resistant bathtubs and shower stalls. At CPSC's urging, industry developed a standard for stepstools to improve stability.

Beginning in 2004, CPSC plans to initiate a project to identify opportunities to assist older consumers in their interactions with consumer products. Possible outcomes of this project are the development of best design practices, new technologies, safety standards, and educational materials.

- *Fires/Burns*:—Fires caused approximately 770 deaths to adults 65 and older in 1998. In comparison to the rest of the population, older adults have significantly higher fire death rates. CPSC is engaged in a number of activities to reduce fire deaths and injuries to older consumers:
  - *Smoke Alarms.*—CPSC recommends the installation and maintenance of smoke alarms on every floor and in every bedroom in the home. However, the elderly tend to experience diminished hearing, often making it difficult for them to hear smoke alarms. CPSC is evaluating smoke

alarm sound effectiveness to determine if improvements can be made.

In addition, CPSC is evaluating current smoke alarm and wireless technologies to determine the feasibility of producing a battery-operated smoke alarm that is interconnected by wireless communication. Interconnection of smoke alarms allows all the alarms to sound if any individual alarm detects smoke. This provides more time for occupants to escape from a home. A large number of homes were constructed before any smoke alarms were required, and protection in these homes may be provided by battery-operated alarms that do not have the added protection provided by interconnected alarms. This may be of particular importance to senior citizens, who frequently live in older homes.

• *Upholstered Furniture and Mattresses/Bedding*.—Older consumers are at greater risk than average of dying from fires involving upholstered furniture and mattresses and bedding. CPSC is currently considering possible mandatory safety standards to address upholstered furniture and mattress flammability and is evaluating the hazard presented by bedding ignition. Based on 1998 data, flammability standards could potentially address 390 deaths and 2,090 injuries associated with mattresses, and 420 deaths and 1,080 injuries associated with upholstered furniture. Many producers of upholstered furniture and mattresses support the development of standards to reduce the flammability of their products.

• *Ranges and Ovens*.—In a special study conducted by CPSC in 1999, over 30 percent of range/oven fire deaths involved consumers aged 65 and older. Ranges and ovens are a leading cause of fires and fire injuries among the products within CPSC's jurisdiction. An estimated 85,000 fires involving ranges (including rangetops and ovens) were attended annually by fire departments during 1994–1998. These fires resulted in an average of 250 deaths, 4,080 injuries and $295.6 million in property loss annually. As part of the CPSC effort to address fires caused by ignition of food on a cooktop or range, staff has demonstrated the feasibility of technologies to detect a pre-fire condition and shut a burner off before a fire occurs. Further work is needed to develop these technologies for commercial application. CPSC also works with industry to provide consumers with information on safe cooking practices.

• *Electrical Wiring in Older Homes*.—Each year, there are an estimated 40,000 home electrical wiring fires. These fires claim over 300 lives each year and cost society $2.2 billion annually. CPSC continues to raise public awareness of hazards with older electric wiring, and we work with fire departments, electrical safety experts, and building code officials to encourage electrical reinspections and upgrades to home electrical wiring systems. Many older consumers live in older homes and these are the homes that are especially vulnerable to electrical wiring fires.

In addition, CPSC staff encourages the use of Arc Fault Circuit Interrupters (AFCIs) to mitigate the risk of fire associated with certain electrical arcing conditions—particularly for existing homes that undergo electrical service replacement. When combined with overload and short circuit protection afforded by circuit breakers and fuses, AFCIs offer the best available safety for preventing electrical wiring fires in homes.

- *Fire Safety Awareness/Clothing Burn Injuries*.—To reduce the risk of clothing burn injuries, CPSC recommends that older consumers look for nightwear that is made of more flame resistant fabrics (flame resistant fibers, wool, silk, nylon and polyester), and that is close-fitting, and easy to remove (e.g., clothes that have quick-release features such as snaps, velcro, or a wrap-style). CPSC joined the National Association of State Fire Marshals and the American Association of Retired Persons to produce a brochure: Fire Safety Checklist for Older Consumers. This easy-to-read brochure highlights fire and burn hazards from smoking, cooking, heating, and electrical appliances. In 2003, CPSC distributed approximately 44,000 copies of this brochure.
- *Scalds*.—Burns from hot tap water are another cause of injury to many older Americans. CPSC recommends that consumers turn down the temperature of their water heater to 120 degrees Fahrenheit to help prevent scalds.

- *Adult-friendly poison prevention packaging*.—Many young children are poisoned when they swallow their grandparents' medicine. Child-resistant (CR) packaging has saved children's lives. However, CR packaging can only work if people choose it and use it properly. To make it easier for all adults, especially older ones, to use child-resistant packaging, CPSC in 1995 adopted a change in its rules for testing packaging under the Poison Prevention Packaging Act. The new regulation requires that packaging be tested by panels of adults 50 to 70 years of age rather than 18 to 45 years old, as was previously the case. This change assures that child-resistant packaging is more "adult-friendly." Industry has developed innovative closures that rely on older people's "cognitive skills" instead of their physical strength. CPSC reminds all adults to keep medicines locked up and out of reach of children.

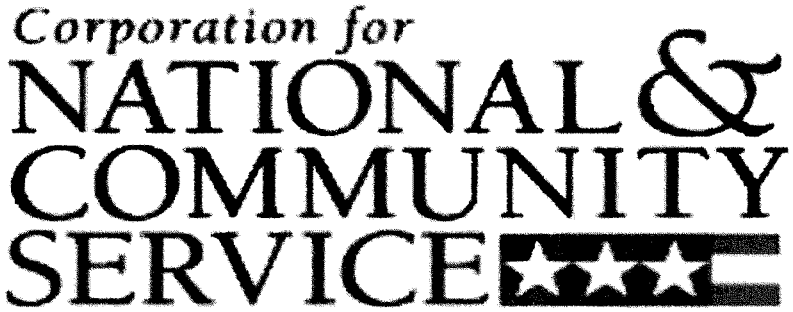
Consumer Information

- In 2003, CPSC distributed approximately 116,000 copies of our *Home Safety Checklist for Older Consumers* (English and Spanish). The *Home Safety Checklist* is a room-by-room check of the home, identifying hazards and recommending ways to avoid injury. Consumers may order a free copy by sending a postcard to "Home Safety Checklist," CPSC, Washington, D.C. 20207.
- In 2003, CPSC distributed 12,800 copies of a brochure developed jointly with the American Academy of Orthopaedic Surgeons (AAOS), *Keep Active and Safe at Any Age.* This bro-

chure gives important tips to older Americans on remaining safe while enjoying the many benefits of exercise.

• These safety tips were based on a CPSC study that found a 54 percent increase in the number of sports-related injuries suffered by older Americans between 1990 and 1996—from 34,400 to 53,000. The brochure stresses that by getting regular exercise-and doing it safely-you can enjoy a healthier life. The brochure emphasizes the importance of wearing safety gear for activities like bicycling and gives tips on warming up and providing variety in exercise routines.

ITEM 14_CORPORATION FOR NATIONAL AND COMMUNITY SERVICE



Developments in Aging
Report for the Special Committee on Aging
United States Senate
107th Congress

Background

On September 21, 1993, the President signed into law the National and Community Service Trust Act, which created the Corporation for National Service. The Corporation's mission is to engage Americans of all ages and backgrounds in community-based service. This service addresses the nation's unmet education, public safety, human and environmental needed to achieve direct and demonstrable results. This commitment to "get things done" is honored by the Corporation's three national service initiatives: The National Senior Service Corps (Senior Corps), AmeriCorps, and Learn and Serve America.

Seniors have long played an integral role in American national and community service. From 1965 (when the Foster Grandparent Program was first implemented as a national demonstration project) to the present day, the federal government has helped seniors benefit from the spirit of service, both as volunteers and as recipients. The Corporation for National and Community Service (the Corporation) is proud to build upon this history.

Through Corporation programs, America's older citizens receive vital services. Grantee service to older recipients includes support for independent living, companionship and medical attention for the frail elderly, respite care for the families of seniors, and transportation for the home-bound. However, older citizens represent much more than a community of need; the Corporation views them as one of the nation's fastest growing natural resources. As the number of older Americans continues to increase, the Corporation recognizes the skills, expertise, and compassion that these individuals offer.

Today, service by seniors is changing the definition of satisfaction and success in post-retirement, and is increasingly regarded as an essential ingredient in productive aging. Senior volunteers demonstrate health benefits, both physical and emotional, and studies show that organized and structured roles and behavior are among the best predictors of increased senior life span (Fried, Freedman, et. al, 1997). Clearly, older Americans have much to offer and to gain from national and community service.

Federal funds benefit seniors through the Corporation's three primary program streams: Senior Corps, AmeriCorps, and Learn & Serve America. Previous Corporation reports to the Senate Special Committee on Aging have focused on the numerous benefits of Senior Corps programs, which involve seniors (both as volunteers and as service recipients) in projects meeting key community needs. For the first time, this year's report also includes information describing the valuable interactions between aging citizens and the AmeriCorps and Learn & Serve America program streams. AmeriCorps has a distinguished history of service to seniors, and today the program is placing a strong emphasis on the active recruitment of senior volunteers. Meanwhile, Learn & Serve America has long involved seniors in its efforts to connect service with education, including intergenerational partnerships with Senior Corps programs.

The Corporation is proud to support such a strong and varied collection of programs. We hope that this year's report to the Senate Special Committee on Aging clearly demonstrates the multifaceted benefits that America's seniors derive from national and community service.

Senior Corps

Overview

SENIOR CORPS: NEARLY FORTY YEARS OF LEADERSHIP IN SENIOR VOLUNTEERISM AND SERVICE

Senior Corps programs have long provided meaningful and cost-effective benefits to aging Americans. Three programs comprise the Senior Corps; the Foster Grandparent Program, the Retired and Senior Volunteer Program, and the Senior Companion Program. These three programs were previously administered by the federal agency ACTION and its predecessors:

- The **Foster Grandparent Program**, started in 1965, provides a way for income-eligible people age 60 and older to serve as extended family members to children and youth with exceptional needs.
- The **Retired and Senior Volunteer Program** (RSVP), started in 1971, is one of the largest volunteer efforts in the nation, engaging people age 55 and older in a diverse range of volunteer activities including organizing neighborhood watch programs, tutoring children, renovating homes, teaching English to immigrants, and assisting victims of natural disasters.
- The **Senior Companion Program**, started in 1974, provides a way for income-eligible people age 60 and older to provide assistance and friendship to adults who have difficulty with daily living tasks, such as grocery shopping and bill paying.

Table 1: National Snapshot of the Senior Corps Programs[1]

Program	Number of Local Projects (including non-Corporation funded projects)	Number of Volunteers	Volunteer Hours of Service to Communities
FGP	323	35,000	27.4 million hours
RSVP	758	489,000	78.2 million hours
SCP	188	17,000	13.9 million hours
Totals	**1,269**	**541,000**	**119.5 million hours**

Table 2: Senior Corps Programs in the Community

[1] Source for all Senior Corps program and volunteer related data: Final Summary – 2002 End of Year Report, Corporation for National Service, National Senior Service Corps.

Program	Number of Local Projects/Grantees	Number of Census Districts Served	Number of Local Public and Nonprofit Agencies that serve as volunteer stations* for Senior Corps volunteers
FGP	323	1,392	11,300
RSVP	758	1,727	66,700
SCP	188	856	9,666
Totals	**1,269**	**3,975**	**87,666**

*Volunteer stations are the places where Senior Corps volunteers serve.

FEDERAL FUNDING: A COST-EFFECTIVE FEDERAL INVESTMENT TO BENEFIT LOCAL COMMUNITIES

The total federal funding for National Senior Service Corps programs in fiscal year 2002 was **$206 million**, apportioned among each of the three programs as follows:

Table 3: National Senior Service Corps FY '02 Federal Funding[2]

Senior Corps Program	FY '02 Funding
Foster Grandparent Program	$ 106.7 million
Retired and Senior Volunteer Program (RSVP)	$ 54.9 million
Senior Companion Program	$ 44.4 million
Total	**$ 206.0 million**

Senior Corps projects are administered by a local nonprofit organizations or public agencies which serve as grantees. As a result, volunteer activities reflect a mix of needs unique to each community. The projects then place the volunteers with other organizations and government agencies in the community. The community-driven focus is, in large part, a reason for the local non-federal support enjoyed by Senior Corps programs.

[2] Source for fiscal data: FY '02 federal appropriation, Corporation for National Service, National Senior Service Corps.

Table 4: Senior Corps Programs and Non-Federal Local Contributions

Senior Corps Program	FY '02 Federal Investment	Non-Federal Local Contribution [3]	Percentage of Non-Federal Support for Every Federal Dollar [4]
Foster Grandparent Program	$ 106.7 million	$ 40.5 million	38 percent 38 cents per dollar
Retired and Senior Volunteer Program (RSVP)	$ 54.9 million	$ 49.0 million	89 percent 89 cents per dollar
Senior Companion Program	$ 44.4 million	$ 27.4 million	62 percent 62 cents per dollar
Total	**$ 206.0 million**	**$ 116.9 million**	

Senior Corps volunteers make it possible for local agencies to provide greater levels of service within their relatively small operating budgets. The monetary value of the volunteer services provided by Senior Corps volunteers is approximately 2 billion dollars. [5]

Table 5: Senior Corps Programs and Return on the Federal Investment

Senior Corps Program	FY '02 Annual Volunteer Service Hours	Value of Service	Return on Federal Investment
Foster Grandparent Program	27.4 million hours	$ 453.2 million	4-fold return
Retired and Senior Volunteer Program (RSVP)	78.2 million hours	$ 1.3 billion	24-fold return
Senior Companion Program	13.9 million	$ 229.9 million	5-fold return
Total	**119.5 million hours**	**$ 2.0 billion**	

3 National Overview 2002 Foster Grandparent Program, National Overview 2002 Retired and Senior Volunteer Program (RSVP), and National Overview 2002 Senior Companion Program, Corporation for National and Community Service.

4 Amounts are calculated by dividing the non-federal local contribution in FY 2002 (Table 4) by the total amount of federal funding in FY 2002 (Table 3). Percentages are converted into dollar amounts.

5 Based on update to the 2001 Biannual Report, *Giving and Volunteering in the United States*, Independent Sector, which assigned a comparable value of $16.54 per hour to volunteer service (www.independentsector.org).

VOLUNTEER OPPORTUNITIES FOR PEOPLE OVER 55: AMERICA'S MOST ABUNDANT NATURAL RESOURCE

Senior Corps provides more than half a million Americans over 55 the opportunity to contribute their time, skills, wisdom and experience to addressing unmet community needs. At the same time, senior programs emphasize the impact on both the volunteers and the communities served.

Twice as many older adults live in the United States today as 30 years ago and the number of persons over age 55 will double again by 2050. Four factors make older persons the nation's best increasing natural resource: [6]

- **Good Health -** Even of those 65 and over, more than 80 percent report no difficulties with activities of daily living. Between 1990 and 2000, the percentage institutionalized went down from 5.1% to 4.5%.
- **More Time -** Americans are now spending a third of their lives in retirement, freeing large blocks of time each week to engage in additional activities.
- **High Interest -** According to the Independent Sector, a Washington, D.C.-based organization that studies American volunteerism, when persons 55 and older are asked to volunteer, over 70 percent do.
- **A Vital Resource -** Tapping senior volunteers and their lifetime of experience is an extremely cost-efficient way to address critical needs the public and philanthropic sectors are hard-pressed to afford.

Service by seniors is changing the definition of satisfaction and success in post-retirement, and is increasingly regarded as an essential ingredient in productive aging. For example, in a follow-up of the MacArthur Successful Aging study, participation in volunteer activities was predictive of improved functioning in older adults, with 32 percent of volunteers showing lower risk of poor physical function, independent of being physically active. There is preliminary evidence from the same study that the amount of time one is involved in formal volunteering activities is important in conferring health benefits, with greater time involvement predictive of the level of physical functioning two years later. Finally, there is evidence that organized and structured roles and behavior are among the best predictors of longer survival (Fried, Freedman, et. al, 1997). It follows, therefore, that public investment in volunteer service by seniors is not only prudent, but that it has multiple benefits. [7]

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6 U.S. Census Bureau, National Population Projections, (NP-T3) Projections of Total Resident Population by 5-Year Age Groups, and Sex with Special Age Categories: Middle Series, 1999-2100.

7 Seeman, T., Singer, B., McEwen, B., Horwitz, R., and Rowe, J. (1997) *MacArthur Successful Aging Study*

NATIONAL SENIOR SERVICE CORPS
SIGNIFICANT ACTIVITIES 2001-2002

Senior Corps Volunteers: Meeting Community Needs

Senior Corps enrolled over half a million people over the age of 55 in both 2001 and 2002, helping our nation's communities meet their most compelling needs. They provided countless hours of service in schools, health clinics, homeless shelters, neighborhood centers, food banks, and other places where there was public work to be done. Senior Corps volunteers also stood alongside others at the World Trade Center and the Pentagon to aid the victims of the terrorist attacks.

The Corporation has asked its grantees to focus more resources on capacity building. This is in response to President Bush's call on Americans to devote at least two years of their lives to service, but it also reflects what we have learned in the past decade. Although the tutoring, health care, environmental clean-up and other services Senior Corps volunteers provide directly are valuable, RSVP volunteers in particular – because they are part of a structured program – can help build the capacity of organizations where they serve by recruiting, supporting, and managing volunteers.

In 2001 and 2002, Senior Corps, as part of the agency-wide effort at the Corporation for National and Community Service, adopted numerous programmatic, accountability, and management and flexibility priorities. These include:

- supporting the President's Call to Service by expanding the number of senior volunteers;
- assisting in homeland security efforts by assigning volunteers to emergency response and relief organizations, police, fire, and law enforcement agencies;
- strengthening performance measurement standards as part of the Government Performance Results Act requirements;
- increasing emphasis on Senior Corps volunteers helping to mobilize other volunteers;
- revising regulations to expand flexibility for grantees and volunteers, and;
- continuing to focus on the needs of children and youth and independent living services for seniors.

President's Call to Service

The September 11 attacks and the possibility of future terrorist actions created daunting new challenges in the area of homeland security. New threats and increased demands face our nation's public safety, health and emergency preparedness officials. In his 2002 State of the Union address, President Bush called on all Americans to serve their country for the equivalent of two years and announced the creation of the USA Freedom Corps. This initiative works to strengthen and expand federal service program such as the Peace Corps, Citizens Corps, AmeriCorps, and the Senior Corps, and to raise awareness of and break down barriers to service opportunities within all federal government agencies.

To fulfill the President's challenge, Senior Corps is working to expand senior service to 600,000 volunteers. The cornerstone of the plan is to enroll senior volunteers through the Senior Corps

web-based recruitment system. The Corporation also began updating data to quantify Senior Corps volunteer contributions to homeland security, child mentoring, and independent living services. In addition, all RSVP grantees were directed to place some volunteers to specifically recruit and mobilize other volunteers in the community.

In June 2002, the Corporation launched a web-based recruitment and placement system for senior service, entitled *Join Senior Service Now (JASON)*, using Senior Corps Demonstration Program funds. The system was made operational for public use in June 2002. This was part of the Corporation's efforts to develop and support products and activities to attract and recruit senior volunteers, as well as ways to increase public awareness of, and appreciation for, the valuable services provided by Senior Corps volunteers. JASON helps the Senior Corps and its grantees recruit volunteers, as well as AmeriCorps programs that are seeking community volunteers to augment the enrolled members. A strategy is to use the web-based recruitment system as a capacity-building tool with and among organizations that are interested in recruiting senior volunteers, including national organizations and local nonprofits seeking volunteers over the age of 55. With its capacity to place seniors into thousands of available opportunities nationwide, JASON has provided these organizations with a new resource for finding experienced and skilled volunteers for meeting critical organizational and community needs.

National Service - Homeland Security and Public Safety

The September 11 tragedy profoundly affected the Corporation's work in 2001 and 2002 as it implemented the President's service initiatives to support homeland security. The Corporation committed $29 million to fund new homeland security programs involving more than 37,000 AmeriCorps and Senior Corps volunteers. The Corporation also worked closely with state service commissions and Corporation state offices to bolster emergency preparedness and response efforts at the state and local levels.

On July 18, 2002, the Corporation announced over $10.3 million in grants to support homeland security efforts. These grants support the recruitment of volunteers for local efforts to develop disaster response plans, expand Neighborhood Watch and Community Emergency Response Teams, establish Medical Reserve Corps, train youth to cope with disasters, disseminate information on bioterrorism, and assist ham radio operators and volunteer pilots in responding to disasters.

Public safety is one of the service priorities of the Corporation. Thousands of volunteers serve with and for police departments and land management agencies. They are not armed, nor can they make arrests, but they carry out vital tasks, including organizing neighborhood watch groups, community policing, victim assistance, fingerprinting and other administrative tasks that free officers to do front line work. In 2001 alone, senior volunteers carried out 131,000 patrols that freed up 540,000 hours of police time. Since September 11, public safety agencies are facing increased demands due to new security threats requiring extended shifts at the same time many personnel are being called up for reserves. Senior Corps volunteers can help fill the gap by expanding their support for police, fire, and law enforcement agencies.

Senior Corps volunteers provide a variety of public health services including immunizing children and adults, serving as case managers, distributing health information, and providing health screenings. In 2001, Senior Corps volunteers assisted in immunizing 270,000 children

and adults.

The resources of public health agencies have been stretched since September 11. Senior volunteers support these organizations, particularly in reaching out with health information to low-income communities. Senior Corps volunteers also work with city health and emergency preparedness offices to help develop public health strategies for responding to municipality-wide emergencies.

From hurricanes and tornadoes to forest fires to floods, Senior Corps volunteers specially trained in disaster relief have responded to disasters in more than thirty states. The Corporation has a long track record of working with FEMA and other relief agencies in helping run emergency shelters, assisting law enforcement, providing food and shelter, managing donations, and helping families and communities rebuild. Hundreds of national service volunteers have directly assisted victims of the September 11 terrorist attacks by providing family services, organizing blood drives, raising funds, and supporting and comforting victims' families.

Building on this record, the Corporation placed additional senior volunteers in assignments targeted specifically at disaster relief, preparedness, and mitigation. Senior Corps volunteers helped, and will continue to help, to support state and community capacities to respond to emergencies and support the long-term recovery efforts in New York City and other areas impacted by disasters.

Strengthening Performance Measurement and Accountability

Senior Corps has evolved over the years and now strives to provide a high quality volunteer experience by focusing on the outcomes of service. *Programming for Impact* (PFI) is the framework that was developed by the Senior Corps in 1996 to facilitate this evolution. It advocates an approach to service programming that integrates community need, accomplishment and impact into station and volunteer assignment, planning, and reporting. It also measures responsiveness to the community and thereby fosters recognition of seniors as a vital, valuable resource.

The emphasis on meeting critical community needs was a radical shift from the way the programs had operated for 25 years. Historically, they focused almost exclusively on the well-being of the volunteer. Senior Corps developed a deliberately phased and incremental plan, designed to let PFI take hold at the grassroots level in three phases. The first phase, completed in 1999, worked to develop core knowledge and experience focusing on volunteer placements and volunteer numbers. The second phase, implemented in 1999 through 2003, moved program goals from volunteer numbers to outcome-based volunteer service activities. The final phase, which will be completed in 2006, looks for evidence of quality accomplishments and end outcomes.

As a vehicle to achieve accomplishment and outcome based programming, PFI also positioned Senior Corps to meet Government Performance and Results Act (GPRA) requirements. As a result of the 1993 Government Performance and Results Act, appropriation decisions will now be based on performance and results of federal agencies. Adding an outcome based focus, PFI is one of the Performance Indicators for Senior Corps' GPRA goals.

The Corporation began a systematic overhaul of its performance-measurement systems in 2002, including requirements for grantees to track, measure, and report against indicators that they nominate.

By the end of 2004, the Corporation will have instituted several reforms to its performance measurement system: ensuring that grantees and sub-grantees have measurable performance measurements linked to their outcomes; setting comparative performance standards on important dimensions regarding the management of service programs and the outcomes of their service activities; building the capacity of local programs to assess the outcomes of their work, and; improving the quality of data on performance used by the Corporation oversight and funding decisions.

Management and Flexibility

Senior Corps made revisions to the federal regulations governing its Foster Grandparent Program and Senior Companion Program to insure flexibility. These changes included:
1. increased flexibility to sponsors in determining the hours of service;
2. reduced restrictions on sponsors serving as volunteer stations, and;
3. clarified income used to determine eligibility for stipend.

The Senior Corps joined all parts of the Corporation in making a greater effort to reach out to and work with faith-based organizations. Senior Corps grantees, as intermediary organizations, provide a mechanism by which a number of community grassroots groups may access Senior Corps volunteers. Across the country, community organizations, both secular and faith-based, are on the front lines working to improve lives in some of the most vulnerable communities across America. The religious commitment and identification with the local community found in many of these groups sustain their service, often over long periods of time. The programs and activities supported through the Corporation already give vital help to these front-line workers in their community-based efforts.

Senior Corps conducted a survey of its grantees in 2001 to determine the level of involvement of faith-based organizations in its programs. The results reported that a substantial number of Senior Corps projects place volunteers with faith-based organizations. On average, these projects have partnered with faith-based organizations for 17 years, and 11 percent of Senior Corps volunteer stations are faith-based.

Focusing on the Needs of Children and Youth and Independent Living Services for Seniors

In 2001 and 2002, the Senior Corps continued to focus its programs on addressing the needs of children and youth, including at-risk youth, children of prisoners, and children in foster care.

According to Department of Justice statistics, 721,500 inmates in the United States are parents of minor children. As of 1999, there were about 1.5 million of these children, reflecting an increase of 38 percent since 1991. Statistically, this is one of the highest risk groups of children in the nation. Many RSVP and FGP projects have relationships with local organizations that serve

these vulnerable children and families. These partnerships and relationships can be tapped to develop service strategies and discrete roles for volunteers in mentoring children.

According to the Children's Bureau of HHS's *Administration on Children, Youth and Families,* over half a million children across the country are in the foster care system. These children are placed with foster parents, or in group homes and institutions. Children who enter the foster care system bring with them many special needs. Often they have been victims of physical abuse, sexual abuse, or neglect. They may suffer moderate to severe emotional, behavioral, or developmental problems. Infants and young children with medical complications, physical handicaps, or mental limitations represent the fastest-growing population in need of foster care. RSVP and FGP volunteers can serve children in foster care as part of their service in schools, after-school programs, community based organizations and other settings.

The Senior Companion Program and some RSVP projects continue to help thousands of seniors to live independently in their own homes. America faces a major long-term care challenge as the population ages and people live longer lives. In 2001 seven million men and women over the age 65 needed long term care. Most of long term care support is provided at home with family members and friends being the caregivers for at least 70% of individuals. Senior Companions have long provided in-home assistance and companionship, as have many RSVP volunteers.

FOSTER GRANDPARENT PROGRAM

Program Overview

The Foster Grandparent Program began in August 1965 as a national demonstration effort. Since its inception, the Foster Grandparent Program has provided young and old the chance to grow together. Today, nearly 35,000 Americans serve as Foster Grandparents. They give care and attention every day to 275,000 children and youth with special and exceptional needs, more than 100,000 are served on an ongoing and daily basis. In improving the lives of children they serve, Foster Grandparents also profoundly enrich their own lives.

In 2001-2002, **35,000 Foster Grandparents** gave care and attention to **275,000 children and youth** with special and exceptional needs.

Foster Grandparents volunteer in schools, hospitals, drug treatment centers, correctional institutions, and Head Start and day care centers. They help children who have been abused or neglected, mentor troubled teenagers and young mothers, and care for premature infants and children with physical disabilities. This special care helps young people grow, gain confidence, and become more productive citizens. In the process, Foster Grandparents strengthen communities by providing personalized services to special needs children that community budgets cannot afford and by building strong bridges across generations.

Foster Grandparents must be at least 60 years of age and meet certain income eligibility requirements in order to receive a small cash stipend. They serve 15 to 40 hours per week and receive pre-service orientation and then ongoing in-service training. In return for their service, income-eligible Foster Grandparents receive a stipend of $2.65 an hour, accident and liability insurance and meals while on duty, reimbursement for transportation, and monthly training.

Non-Federal Support and Return on Federal Investment

Foster Grandparent projects are jointly funded by federal, state, and local governments, with significant support from the private sector. The federal budget to support these projects was $99.2 million in fiscal year 2001 and $106.7 million in fiscal year 2002. The non-federal local contribution averaged $40.5 million annually or 38 cents for every federal dollar invested in 2002 - well above the 10 percent match required by law and attesting to the success of Foster Grandparents in the communities they serve.

In 2002, almost 24,000 volunteer service years* were supported by federal funds and 2,500 were funded from other sources through existing local projects supported by the Corporation, state, local, and private funds. A volunteer service year equals 1,044 hours.

The 27.4 million hours of service provided annually by Foster Grandparents was worth over

* A volunteer service year is the budgeting measure to estimate cost per year. It is similar to an FTE. A volunteer service year equals 1,044 hours per year. It is not the same as number of actual volunteers.

$453 million, according to a study by the Independent Sector. This represented more than a four-fold return on the federal dollars invested in these projects.

Following procedures designed in 2002, Foster Grandparent project directors will continue to measure the impact of volunteer activity using well-recognized indicators related to the types of children with special needs served by Foster Grandparents.

During fiscal year 2001, a research firm under contract to the Corporation surveyed community representatives about the Foster Grandparent Program and the services it delivers in the community through volunteers. Responding to the survey were community representatives who either worked for organizations that received Foster Grandparent services, worked with recipients of Foster Grandparent services, supervised Foster Grandparents, lived in the community where the Foster Grandparent Program provides services, or were affiliated in some other way with the program's activities. Findings from this study include:

- 81% of respondents rated Foster Grandparent services as at least "very important".
- 99% of respondents rated Foster Grandparents as meeting or exceeding expectations.
- 78% of respondents said that Foster Grandparent volunteers met needs that were not adequately addressed by other services in the community.

NATIONAL PROFILE OF FOSTER GRANDPARENT VOLUNTEERS

Characteristics	Percent (%)
Distribution by Gender:	
Female	91%
Male	9%
Distribution by Age:	
60 – 64 years	14%
65 – 74 years	49%
75 – 84 years	32%
85 and over	5%
Distribution by Race:	
White	55%
African American	39%
Asian/Pacific Islander	3%
American Indian/Alaskan Native	3%
Ethnicity:	
Hispanic/Latino	10%

The annual Federal cost of a Foster Grandparent serving 20 hours a week is $4,500

FOSTER GRANDPARENT PROJECT EXAMPLES

Wayne Action Group For Economic Solvency Foster Grandparent Program
(North Carolina - Helping Teen Mothers and Their Babies)

Foster Grandparents serving with the Wayne Action Group for Economic Solvency (WAGES) project provide support for teenage mothers and their children. They go to the mothers' homes, mentoring the mothers in home management and parenting skills, while providing nutritional and nurturing support for their babies.

The teen moms are making responsible decisions and getting their lives, and those of their babies, on track, thanks to the guidance and support of the Foster Grandparents. Four of the mothers went back to school and three earned their GED certificates. These achievements were possible because the Foster Grandparents cared for the babies while their moms were in school. Four of the mothers are now employed. None have become pregnant since they were served by a Foster Grandparent.

In-home placement of Foster Grandparents has proven a positive response to the challenges created by the growing number of teen mothers in Goldsboro and Wayne County, North Carolina.

FOSTER GRANDPARENT PROJECT EXAMPLES (Continued)

- **Foster Grandparent Program of Eastern/Central Oregon**
  (Pendleton, OR - Reading Skills)

During summer months, elementary school-age children in rural counties around Oregon are at risk of losing some of the gains made in reading skills during the regular school year. The Foster Grandparent project collaborated with local school districts and community libraries to provide one-to-one reading support to children whose reading skills were identified as weak by their classroom teachers during the school year.

Twenty-nine Foster Grandparents provided one-to-one reading reinforcement support to 400 children with weak reading skills during a six week summer program in 2002. Reading scores increased by more than a full point for the children, as measured by state assessment tests.

- **FGP of Madison, Clinton and Marion Counties**
  (Alton, Illinois - Mentoring At-Risk Youth)

Madison, Clinton, and Marion Counties are all economically depressed areas with decreasing populations, limited community resources, and a rise in poverty as businesses and factories close. One junior high and 14 elementary schools have over-crowded classrooms due to school consolidation and a large influx of Spanish-speaking residents.

Forty-six Foster Grandparents served one-on-one with at least 184 elementary school children, 5 days a week, for 9 months, each school year. Although the goal is for Foster Grandparents to work one-on-one, they interact in positive ways with nearly all the students, and the teachers' evaluations indicated that a total of 1,040 students had received some kind of assistance.

Teachers credit the Foster Grandparents with the following positive changes in children's behavior or skills: 87 % bond with the volunteer, 72% improved social skills with peers, 76% improved social skills with adults, 75% improved classroom behavior, 77% strengthened bonding to academics, 92% showed respect for the volunteer, 46% experienced enhanced self-esteem, 81% increased their self-confidence, and 73% improved academic performance.

- **Columbus Foster Grandparent Program**
  (Columbus, IN - Improving Math and Reading Skills)

On a state wide academic skills test, scores for children in Bartholomew, Brown, Decatur, Jackson, and Jennings Counties show that 39% of third graders, 49% of sixth graders and 44% of eighth graders were below their respective grade level. Poor social-behavioral skills were a contributing factor to lower test scores.

Serving as tutors and mentors to 390 children in public and parochial elementary and middle schools, seventy-eight Foster Grandparents played an important role in increasing the children's math skills by 35%; language arts by 40%; social behavior by 41%; and their self-esteem by 58%.

SENIOR COMPANION PROGRAM

Program Overview

The Senior Companion Program awarded funds to its first projects in August 1974. This program recruits persons age 60 and over to provide assistance and friendship to frail adults, mostly the elderly who are homebound and living alone. The services Senior Companions provide help others to live independently in their own homes instead of moving to expensive institutional care. Senior Companions also provide respite care for short periods of time to relieve caregivers.

In 2001-2002, over **17,300 Senior Companion volunteers** served more than **61,000 frail older persons.**

By assisting clients with simple chores, providing transportation to medical appointments, and offering needed contact to the outside world, Senior Companions often provide the supportive services that the frail need to continue to live independently. Because Senior Companions spend significant periods of time with their clients, they are often a critical part of the client's "care team." Senior Companions alert doctors and family members of potential health problems, allowing them to provide immediate care to the client.

Senior Companions serve three to four clients in an average week, predominately in the clients' own homes. Community organizations that address health needs of the elderly such as home health care agencies, hospitals, or centers on aging serve as volunteer stations. These organizations identify individuals who need assistance and then work with Senior Companion projects to match them with available Senior Companions.

Senior Companions serve 15 to 40 hours per week helping two to four adult clients live independently in their own homes. Like Foster Grandparents, income-eligible Senior Companions also receive pre-service orientation and ongoing training throughout their service. Income-eligible Senior Companions receive $2.65 an hour to offset the cost of volunteering. They are provided transportation, some meals during service, an annual physical, and accident and liability insurance while on duty.

Community organizations using the services of Senior Companions were able to help additional clients, and provided additional services to present clients. By providing their direct and respite support to clients, Senior Companions helped to free up the time of paid professional staff, thus allowing them to undertake more duties.

Compared with the average cost of nursing home care, which exceeds $47,000 annually, the annual cost for Senior Companion services is $4,200. This is a very cost-effective way to provide one of the important supportive services needed for independent to the average five frail adults served by each Senior Companion.

Non-Federal Support and Return on Federal Investment

In 2002, Senior Companions provided services to 44,600 frail adults weekly and to more than 61,000 annually. More than 17,000 Senior Companions served in 188 projects to provide personal assistance and companionship primarily to persons who have physical, mental, or emotional impairments, predominantly the frail elderly. The federal budget for Senior Companions was $44.4 million in fiscal year 2002. The non-federal local contribution to these projects was $27.4 million. This non-federal contribution represented a support of 62 percent, or 62 cents for every federal dollar invested - well above the 10 percent match required by law.

In fiscal year 2002, the 13.9 million hours of service provided annually by Senior Companions was estimated to be worth $230 million, according to a study by the Independent Sector. This represents almost a five-fold return on the federal dollars invested in the program.

Senior Companions provide older, frail adults much-needed care, companionship, and support, according to surveyed community representatives. A research firm under contract to the Corporation surveyed community representatives about Senior Companion Program grantees and the services it delivers in the community through volunteers. Responding to the survey were community representatives who either served as a board member of an affiliated organization, lived in the community where the Senior Companion Program provides services, supervised Senior Companions, worked with recipients of Senior Companion services, or worked for organizations that received Senior Companion services. Findings from this study include:

- 82% of respondents rated Senior Companion services as, at a minimum, "very important"
- 79% of respondent indicated that Senior Companion services addressed needs at least "somewhat critical" and that the services were provided in a timely manner
- 96% of respondents said that the services met or exceeded expectations

The complete study can be downloaded from the Senior Corps website at http://www.seniorcorps.org/research/index.html.

NATIONAL PROFILE OF SENIOR COMPANION VOLUNTEERS

Characteristics	Percent (%)
Distribution by Gender:	
Female	85%
Male	15%
Distribution by Age:	
60-64 years	15%
65-74 years	49%
75-84 years	31%
85 and over	5%
Distribution by Race:	
White	58%
African American	35%
Asian/Pacific Islander	4%
American Indian/Alaskan Native	2%
Ethnicity	
Hispanic/Latino	11%
The annual Federal cost of a Senior Companion serving 20 hours per week is $4,600.	

PROJECT EXAMPLES

Wyoming Senior Companion Program *(Casper, WY – Reducing the Costs of Senior Care)*

The city of Casper has a population of about 50,000. Currently, the Natrona County Senior Center maintains a roster of nearly 3,400 seniors, 4.8% of whom need in-home services in order to remain independent. The current cost of nursing home care in the area is about $108 per day or $39,420.

Senior Companions provide the usual services; socialization, recreation, respite and hospice personal care, nutritional support, home management, client advocacy and information. In 2002, Senior Companions served an average of 1,100 hours. The average caseload for Companions is 5 clients on any given day; twelve Senior Companions served approximately sixty-seven clients. There is a potential savings of $2,641,140 for each year the program is served by Senior Companions.

SENIOR COMPANION PROJECT EXAMPLES (Continued)

- **Garland County SCP**
  (Hot Springs, AR - Helping to Ensure Independent Living for Seniors)

Four HUD apartment complexes in Hot Springs are home to 120 seniors with fixed incomes and little-to-no family assistance. Many have dementia or physical limitations. To assist them to maintain their independence Senior Companions provide in-home care for 80 to 100 HUD complex residents annually. The Senior Companions provide needed assistance with personal grooming, light housework, shopping, doctor's appointment accompaniment, advocacy, and companionship. The cost for institutionalization for each client would be approximately $2,500 to $3,000 monthly. The cost for a Senior Companion for each client is approximately $212 monthly, a per client savings of from $2,288 to $2,788 to the local community.

- **Kent/Sussex/Newcastle SCP**
  (Georgetown, DE - Helping Clients with Alzheimer's Disease)

One component of the statewide Senior Companion project focuses on placing Senior Companions in the homes of low and middle-income families who need help caring for an older family member with Alzheimer's disease. Senior Companions are placed through the Alzheimer's Association of Delaware to care for Alzheimer's patients, provide caregivers with needed respite and time to pursue other activities, including shopping and employment. The Senior Companions currently serve ten clients.

- **Wasatch Senior Companion Program**
  (Provo, UT - Deferring Costs of Institutionalization)

Thirty-two Senior Companions provided care and companionship for 208 in-home clients, enabling them to remain independent. They helped with household chores and transported their clients to medical appointments, food and drug stores. Thanks to the Senior Companions, clients delay or defer institutionalization, at a potential savings to the clients, their families, and the public of over $7.4 million annually.

Retired & Senior Volunteer Program (RSVP)

Program Overview

RSVP (Retired and Senior Volunteer Program) was launched in 1971. RSVP, one of the largest volunteer efforts in the nation, matches the personal interests and skills of seniors age 55 and older with opportunities to help solve the problems in their communities and meet the needs of their fellow citizens. RSVP volunteers choose how and where they want to serve -- from a few to over 40 hours a week in a wide range of community organizations such as hospitals, youth recreation centers, schools, and local police stations.

RSVP volunteers provide hundreds of community services. They organize neighborhood watch programs, tutor children, renovate homes, teach English to immigrants, assist victims of natural disasters, and a myriad of other community services. Through such efforts, RSVP is meeting community needs that strained local budgets cannot afford to address.

In 2001-2002, **RSVP** volunteers provided over **78 million hours** of service to individuals needing assistance with **health** and **nutritional concerns**. The volunteers helped individuals who are mentally, developmentally and physically disabled; rehabilitating from alcoholism and drugs; and those suffering from HIV/AIDS. The volunteers also provided health education, nutritional support, and in-home care for those needing peer support and meal preparation.

RSVP continues as a well-established volunteer program for Americans 55 and over. More than 489,000 volunteers served a few hours a week to nearly full-time at an estimated 66,700 local and national nonprofit groups, faith-based organizations, and government agencies. Volunteers do not receive a stipend, but sponsoring organizations may reimburse them for some costs incurred during service, including meals and transportation.

RSVP projects are jointly funded by the federal government, state and local governments, and the private sector. RSVP's federal budget was $54.9 million in fiscal year 2002. The non-federal local contribution to RSVP projects was $49.0 million, demonstrating broad support for RSVP across the country. For every federal dollar invested, 89 cents was contributed from non-federal sources in 2002. Of the combined RSVP cost, federal funding provided 52 percent, while 48 percent of the costs were borne by local funding sources.

According to the study conducted by the Independent Sector, the over 78 million hours of service provided annually by RSVP volunteers had an estimated worth of over $1.3 billion. This represented approximately a 25-fold return on the federal dollars invested in RSVP. [5]

RSVP provides a wide range of services that are highly valued by community members. During fiscal 2001, the Corporation contracted with a research firm to survey community representatives about

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5 Based on update to the 2001 Biannual Report, *Giving and Volunteering in the United States*, Independent Sector, which assigned a comparable value of $16.54 per hour to volunteer service (www.independentsector.org).

RSVP and the services it delivers in the community through RSVP volunteers. The responses were as follows:

- 83% of respondents rated RSVP services as "very important" or "extremely important"
- 95% of respondents rated the overall satisfaction with RSVP services as meeting or exceeding expectations.
- 57% of respondents rated RSVP services as addressing at least "very critical community needs".

Overall, customer satisfaction among this group of respondents, most of whom live and work in organizations and communities served by RSVP volunteers was high in terms of meeting expectations.[8]

8 Research Triangle Institute. 2002. *Customer Satisfaction Survey*

NATIONAL PROFILE OF RSVP VOLUNTEERS

Characteristics	Percent (%)
Distribution by Gender:	
Female	75%
Male	25%
Distribution by Age:	
55 – 59	4%
60 - 64 years	11%
65 - 74 years	38%
75 - 84 years	37%
85 and over	10%
Distribution by Race:	
White	89%
African American	8%
Asian/Pacific Islander	1%
American Indian/Alaskan Native	>1%
Ethnicity	
Hispanic/Latino	4%
The annual Federal cost of an RSVP volunteer is approximately $400.	

RSVP PROJECT EXAMPLES

RSVP of Pocatello *(Pocatello, ID - Mentoring At-Risk Youth)*

The Pocatello Area RSVP program has seventy RSVP volunteer mentors working with seventy "at risk" students (primarily middle-school age) in nine Public School Districts throughout southeastern Idaho. These are children with social interaction problems and a wide range of family troubles, including parents in jail, parents with drug addictions, and parents who have been suicidal.

The senior mentors meet at least once per week with their students to participate in positive in-school or after-school activities. School officials report anecdotal evidence that all students have had a marked improvement in attitude, school attendance, performance in school, and sense of well-being; preliminary evaluation based on the Search Institutes Developmental Assets framework indicates that these positive adult role models are indeed enabling the children to thrive.

Three other Idaho RSVP projects have ninety additional volunteers serving in similar mentoring roles.

RSVP PROJECT EXAMPLES (Continued)

- **Coastal RSVP**

  (Rockland, ME - Providing Tax Assistance for Low-Income Residents)

In Lincoln, Knox, and Waldo Counties, 14 RSVP volunteers spent 1,387 hours preparing over 500 federal and state income tax returns for 250 low-income residents, including homebound seniors, many of whom cannot read or write proficiently. The Tax Assistance Program, a collaborative effort with AARP, significantly helps the clients to retain financial independence.

- **Hidden Treasure Prison Fellowship**

  (Baton Rouge, Louisiana - Mentoring Children of Inmates)

East Baton Rouge Parish is currently below the state average in school achievement testing; those failing are unable to be promoted to the next grade. Hidden Treasure Prison Fellowship is a support group that provides services to families of the incarcerated and disadvantaged, with a special emphasis on the youth. Nine RSVP volunteers mentor and tutor 22 at-risk children, in first through seventh grades, in the after school program. During the 2001-2002 school year, twenty-one of the twenty-two students advanced to the next grade level.

- **Washoe County RSVP**

  (Reno, NV - Helping to Keep Communities Safe)

The Senior Auxiliary Volunteer Effort (SAVE) is a collaborative effort between the Reno Police Department and RSVP. Since September 11, 2001 the Police Department was overwhelmed by the increased need for their services. SAVE volunteers, screened by a committee of their peers, receive specialized training from the Police Department. Fifty RSVP "SAVE" volunteers participate in school patrols, staff a graffiti hot line and take reports, perform park patrols, vacation home check, *You are not alone* visits to isolated seniors, deliver safety education to children and senior citizens, and report abandoned cars to be towed away. During the first six months of this year, SAVE volunteers contributed 4,922 hours of service to the program; valued at $15.40 per hour, this meant a cost savings of $75,799 for the Reno Police Department.

- **RSVP of Crawford County**

  (Meadville, PA - Serving the Uninsured)

Thirteen RSVP volunteers, eight of them nurses, help provide quality health care to persons without health insurance who cannot afford the cost of health care. Last year, they served 565 patients at the Meadville Area Free Clinic, a community organized volunteer initiative. As a result: 83 new patients were seen and treated; 482 patients were seen for medical follow-up; and 300 patients were referred to other medical facilities and doctors for further treatment.

- **RSVP in Interior Alaska**

  (Fairbanks, AK - Screening the Elderly for Health Complications)

Senior citizens need regular foot health check-ups to avoid the serious consequences of often-debilitating diseases like diabetes. Amputations of toes, feet, or legs are sometimes the tragic consequence of poor circulation or foot ulcers that can be treated easily if diagnosed early. The key to disease prevention is regular foot screenings, patient education, and patient involvement.

RSVP volunteers who are retired nurses prevent serious complications from diabetes and other

diseases through early intervention and treatment, referring patients to their physicians when appropriate. In 2002, they screened more than 600 patients for warning signs of poor circulation, loss of sensation change in skin color, ulcerated open foot sores, foot sores slow in healing, elevation in skin temperature, foot or ankle swelling, ingrown and fungal toenails, bleeding corns or calluses, and dry cracks in heel skin.

AmeriCorps

Overview

AmeriCorps is a national service network that provides full and less than full-time opportunities for participants, called members, to serve their communities and build the capacity of nonprofit organizations to meet local environmental, educational, public safety, homeland security, or other human needs. Within these five issue areas, programs may submit proposals that address specific problems of local communities. Local needs drive AmeriCorps.

The AmeriCorps national service network includes AmeriCorps*State and National programs, Indian Tribe and U.S. Territories programs, Education Awards Program, AmeriCorps*Promise Fellows, AmeriCorps Volunteers in Service to America (VISTA), and AmeriCorps National Civilian Community Corps (NCCC). Through service with local organizations and agencies, in communities large and small throughout America, AmeriCorps members serve their Nation.

AmeriCorps members' service addresses community needs in one of four areas: education, public safety, human services and the environment. Here are some of the types of service AmeriCorps members perform:

- tutor teens and teach elementary school students
- assist crime victims or start neighborhood crime watches
- turn vacant lots into neighborhood parks
- provide assistance and companionship to homebound elderly or individuals with disabilities
- lead community health awareness campaigns
- restore coastlines
- respond to natural disasters with emergency relief for victims

AmeriCorps members receive a modest living allowance, health coverage, and child care for those who qualify. After successfully completing a year of service, they receive an education award of $4,725. This award can be used to pay off student loans or to finance college, graduate school or vocational training.

In addition to these benefits, AmeriCorps members learn new skills, acquire qualities of leadership, and gain a sense of satisfaction from taking on responsibilities that directly affect peoples' lives.

After completing one year of full-time service (from 10 to 12 months), AmeriCorps members receive an education voucher worth $4,725. The voucher can be used to cover future costs of college or vocational school and to pay back qualified student loans. AmeriCorps members are U.S. citizens, nationals, or lawful permanent resident aliens of the U.S. and at least 17 years of age.

In the short time since AmeriCorps' inception, its members have achieved impressive results. This year, more than 60,000 AmeriCorps members will serve communities throughout the country.

Historically, senior service and senior issues have played an important role in AmeriCorps (see individual program sections for examples). This involvement produced remarkable dividends (see Section F, "The Benefits of AmeriCorps Placement for Aging Americans," for examples). Additionally, AmeriCorps staff is seeking to expand seniors' roles in the program through active recruitment, as described in the next section.

AmeriCorps Recruitment

Interest Levels in AmeriCorps Among Senior Volunteers

Nearly 3% of online AmeriCorps applications received by the Corporation are from individuals over 50 years of age, while nearly 6% of all AmeriCorps members are 50 or older.

AmeriCorps Recruitment Efforts Targeting Seniors

As the number of older Americans continues to grow, the Office of AmeriCorps Recruitment is working to expand traditional organizational alliances, nationally and locally, to include outreach to senior-oriented organizations. To facilitate this expansion, the Corporation is developing an AmeriCorps brochure which targets older audiences. The AmeriCorps Recruitment staff is also increasingly distributing informational material on Senior Corps programs. This approach enables seniors across the country to view the full range of service opportunities that are available through the Corporation and select what is most appropriate for them.

AmeriCorps State and National Programs

AmeriCorps*National Direct

Nonprofit organizations that operate a program in two or more states are eligible to apply for AmeriCorps*National program grants. This allows the Corporation for National and Community Service to fund multi-state and multi-site programs of a national scope that build on existing networks of youth and service programs. Eligible applicants include partnerships or consortia formed across two or more states, consisting of institutions of higher education, Indian tribes, or other nonprofits, including labor and religious organizations.

AmeriCorps*National Direct programs are sponsored by national organizations to meet the specific needs of the communities they serve. We seek to develop high-quality service programs operated by parent organizations that have:

- national or multi-state networks;
- the existing capacity needed to monitor and support a national service program; and
- experience in operating similar programs.

The parent organization designates operating sites that are responsible for managing, operating, and reporting on high-quality programs. Depending on program design, the operating sites may also be responsible for receipt and disbursement of grant funds. AmeriCorps*National Direct has two programs that provide a wealth of volunteer opportunities to seniors, while meeting an array of community needs.

The parent organization must demonstrate a strong institutional commitment of personnel, resources, training, and technical expertise. The Corporation prefers parent organizations to develop strong and well-coordinated multi-site programs rather than loosely tying together several local programs that should have applied through their state commissions.

The parent organization has several crucial roles and responsibilities in operating a high quality, multi-site AmeriCorps program. All parent organizations are expected to:

- select high-quality operating sites;
- provide ongoing monitoring, technical assistance, and support to operating sites;
- assist in member recruitment, especially with national strategies;
- conduct appropriate training for staff and members;
- foster an ethic of service;
- assist in the coordination of AmeriCorps efforts with state commissions and other local Corporation-funded programs;
- provide strong financial management for the aggregate program and at sites;
- act as liaison between the Corporation and the operating sites;
- work with sites to develop long-term sustainability;
- develop and conduct an aggregate program evaluation;
- ensure that operating sites that receive federal funds (either from the parent organization or other sources) obtain financial statement audits as required under the OMB Circular A-133, obtain and review the audit reports, and follow up on corrective action taken for relevant audit findings;
- establish procedures (in conjunction with obtaining, reviewing, and following up on audit reports) and carry out continuous monitoring of financial management, program performance, and performance measurement at operating sites; and
- submit timely aggregate financial and program reports.

AmeriCorps State

AmeriCorps State provides grants to governor appointed state service commissions to support national and community service activities in non-profits, schools and universities, and local government agencies. There are 51 state commissions, including the District of

Columbia and Puerto Rico. At this time the only state without an appointed commission is South Dakota. Grants are made available to state commissions in two ways:

1) One third of AmeriCorps annual program funds are allocated to states based on their population.
2) At least one-third of AmeriCorps annual program funds are used to support a national competition run by the Corporation for sub-applicants sponsoring national and community service projects in their individual states. To be eligible for funding the sub-applicant must be recommended by the state commission.

State and National Programs Involving Seniors

Two AmeriCorps*National Direct senior programs include:

- **Civic Ventures- Experience Corps**

Founded in 1988, Civic Ventures works to expand the contribution of older Americans to society and to help transform the aging of America into a source of individual and social renewal.

AmeriCorps members engage in one-on-one and small group literacy tutoring; provide site-specific literacy activities such as storytelling; and involve families in their child's school and literacy development by supporting activities such as parent breakfasts and book fairs.

- **University of Maryland, Center on Aging- Legacy Corps**

The University of Maryland Center on Aging is an interdisciplinary entity designed to develop applied demonstration projects, policy studies, research, education, training, technical assistance, and public service for the purpose of attaining the maximum quality of life and health for older persons.

Legacy Corps' mission is to recruit and train older persons as community catalysts to provide an array of health intervention, education, and outreach services that support and enhance the public health service delivery system. Legacy Corps members provide direct prevention and intervention services and education to care givers and frail elders to sustain community-based independent living. Legacy Corps Members are placed with public health related organizations to provide public education and conduct health intervention and health awareness fairs with an emphasis on reaching underserved populations.

In fiscal years 2001and 2002, more than fourteen hundred AmeriCorps members contributed their time, skills, wisdom and experience to addressing unmet community needs, while emphasizing the impact on both the individuals and the communities served. Members are still serving in FY 02. The chart below indicate the numbers of members and hours served as of September 2003.

AmeriCorps State senior programs include:

- **Cape Cod & Island Senior Environmental Corps**

The Cape Cod & Island Senior Environmental Corps (sponsored by the Elder Services of Cape Cod & Islands, Inc.) in Massachusetts is an AmeriCorps initiative developed in 1999 to engage seniors in AmeriCorps programs in environment and technology. The mission of the program is to use the skills and knowledge accumulated over a lifetime by the AmeriCorps senior members (age 50 and older) to address environmental needs of the community. This program aims at giving educated and healthy seniors an opportunity to provide meaningful service to the community.

Senior AmeriCorps members address identified community needs such as the loss of natural habitat for aquatic and terrestrial species and degradation of the quality of coastal resources. Members carry out wetland and wildlife monitoring, as well as environmental education activities. Members conduct water sample collection and testing for chemical contamination, vernal pool certification, beach testing for bacterial contamination, storm drain mapping, and sample testing for contamination and the presence of West Nile mosquito larvae. Members teach, conduct research, and serve as guides at national and state protected areas. Members study and help to rebuild the nesting habitats of endangered birds. Members carry out environmental education activities by distributing information about how residents can avoid Lyme tick disease or West Nile virus, acting as guides on whale watch cruises, restoring trails, and guiding people on natural walks. Members work with community volunteers and children on service learning projects, beach clean up and environmental fairs. In addition, members serve in homeland security and disaster preparedness activities through the development and management of emergency shelters, and preparation of disaster management plans, in collaboration with the Massachusetts Military Reservation.

Fifty percent of the members who graduated have re-enlisted for a second term. In 2002, the program won the Cape Cod Conservation Award, presented at the National Senior Corps Conference.

- **Generations Incorporated AmeriCorps Program**

Another Massachusetts based program is Generations Incorporated, whose mission is to engage generations of older adults and youth in service to strengthen individuals and communities.

The program addresses community needs in the area of education in three of Boston's most underserved communities (Dorchester, Roxbury and South Boston). The program is unique in its innovative approach of leveraging elders as an asset, and using a community volunteer service model as a main strategy to address the community needs and to sustain program activities. AmeriCorps members play a key role in bringing Experience Corps (EC) volunteers, age 55 and older, into service. AmeriCorps members recruit and coordinate over 200 volunteers who serve over 1000 children annually through literacy, mentoring and community learning service programs. The program has three components:

1) GI's literacy program (Leaps in Literacy), which serves as a safety net by uniting under-performing youth with EC volunteers, who provide one to one tutoring. AmeriCorps members coordinate GI Leaps in Literacy program in 11 Boston public school sites and three after school sites; GI uses the Reading Coaches' model to structure one-on-one literacy sessions with first through fourth graders reading below grade level;

2) GI's Future Stars, which is a mentoring program that unites small groups of elementary and middle school youth with EC volunteers once a week for 90 minutes with a focus on homework assistance, community exploration and celebration and life skills; and

3) GI's Generation Clubs, which facilitates long term, one on one relationships between urban elementary and middle school youth and isolated elders in nursing homes, assisted living residences, and other senior facilities.

During the past three years, the program has served over 1,200 youth and over 2,500 community residents. Basic Reading Inventory (BRI) assessment shows that literacy program participants were able to catch, and often surpass, their peers. For instance, in 2002 in Boston alone, through the Leaps in Literacy, 90% of 160 youth served improved their literacy skills by three reading levels, as measured by BRI tests. Community service learning participants improved their self-esteem as well as academic and social skills; older participants experienced a renewed sense of purpose and a greater connection to community.

1. TenneSenior Corps
The Vanderbilt University Medical Center in Tennessee sponsors TenneSenior Corps. TSC addresses the need to decrease the danger and discomfort to senior citizens, especially in their own homes. Members conduct fitness and health promotion activities for senior citizens, with 80% of those seniors evaluated either improving or maintaining their mental and/or physical health levels. Members assist low-income senior citizens in conducting healthy, independent lives by 1) improving the living environment of those living independently; 2) providing home repairs and renovation assistance, which will reduce lead exposure for seniors; 3) conducting home visits for seniors at risk for social isolation, to connect them with other community members and increase their access to services; and 4) recruiting volunteers to provide breast cancer detection information to senior women, which will increase their knowledge about breast health and breast cancer detection.

2. Senior Connections
The Green River Area Development District (GRADD) in Kentucky sponsors Senior Connections. The program addresses the need to provide in-home assistance to at-risk, low-income seniors in rural western Kentucky, with 90% achieving safer living conditions and enhancing their quality of life. Members repair houses, help seniors manage their homes, perform household chores, deliver meals, provide medical benefits counseling, provide respite care, and assess and teach home safety.

TABLE 1. AC* STATE AND NATIONAL SENIOR ORIENTED PROGRAMS APPROVED IN FY2003			
PROGRAM	GRANT FUNDS	FULL-TIME EQUIVALENT	GRANT COST PER FULL-TIME EQUIVALENT
EXPERIENCE CORPS	$1,651,200	129	$12,800
LEGACY CORPS	$697,600	55	$12,800
CAPE COD & ISLAND SENIOR ENVIRONMENTAL CORPS	$160,516	13	$12,347
GENERATIONS INC	$332,800	26	$12,800
TENNESENIOR CORPS	$227,840	18	$12,658
SENIOR CONNECTIONS	$256,000	20	$12,800

AmeriCorps*VISTA

AmeriCorps*VISTA has increasingly become involved with seniors in poverty – a subset of the rapidly expanding elderly population. The poverty rate rises with age. Senior citizens' susceptibility to poverty is magnified by their reliance on a single source of fixed income, leaving them little room for budget errors and vulnerable to inflationary increases.

Poverty among senior citizens is frequently overlooked due to lack of exposure and the misconception that time and resources invested in addressing poverty among the elderly produce short-term results. Programming for seniors in poverty encompasses:

- Health: increasing education about and access to health care benefits;
- Prescription drugs: providing access to free medicine;
- Companionship: meal delivery to the homebound;
- Transportation: providing transportation to medical appointments;
- Housing: conducting home safety visits and identifying and providing for necessary repairs and maintenance;
- Employment: job search clubs;
- Technology: enabling seniors to connect with one another via the Internet; and,
- Financial literacy: preventing financial fraud.

Following are a few examples of AmeriCorps*VISTA projects focusing efforts on senior citizens across the country:

- **Montana Elder Abuse Prevention Project - Helena, Montana**

The Montana Elder Abuse Prevention Project began in Billings, Montana. AmeriCorps*VISTA members were instrumental in developing the first Chapter associated with the National Committee for the Prevention of Elder Abuse in the nation. From those beginnings, AmeriCorps*VISTA members have been involved in helping to establish and develop two more Chapters in Great Falls and Missoula, Montana.

This project has helped communities across Montana understand the prevalence and severity of acts of abuse, neglect, sexual abuse, and exploitation occurring against citizens of the state. Exploitation is a growing problem that is affecting the financial health of many. The three Montana Chapters, with the help of AmeriCorps*VISTA members, are diligently working to assist in fighting financial exploitation through setting up infrastructure for education in identifying and controlling this problem. This is being accomplished by developing needed infrastructure to provide guardianship and conservatory services to those in need to advance the financial security of elders and the disabled.

- **Green Thumb (Experience Works) - Mechanicsburg, Pennsylvania**

Green Thumb, a private non-profit organization, is the nation's oldest and largest provider of disadvantaged and older worker employment and training services. Experience Works combats poverty among seniors by providing job training and employment opportunities to enable them to become self-sufficient through gainful employment. The overall purpose of the AmeriCorps*VISTA project is the development of a training service that focuses on the learning of older adults and provides technology skills today for a job tomorrow. They are also developing a computer learning center targeted at low-income seniors and other disadvantaged job seekers.

- **Gila Aging Services - Miami, Arizona**

AmeriCorps*VISTA members help coordinate the Elder-Building Program to address the problems of isolation and loneliness (and even suicide) among low-income rural elderly, who may or may not live with their family. The members coordinate community volunteers to provide participants easily accessible transportation to the doctor's office or shopping malls or occasionally a lunch, friendly in-home visits, delivery of hot meals, house cleaning, and phone reassurance check-ins. AmeriCorps*VISTA members are serving in the counties of Gila, Pinal, Cochise, Yavapai, and Coconino.

- **Clark County Senior Advocates Program - Las Vegas, Nevada**

The AmeriCorps*VISTA project is designed to ultimately provide expanded services for senior citizens. As a shared resource with service providers in need of assistance with fundraising, grant writing, outreach, volunteer recruitment, and strategic planning, the project focuses on outcomes that benefit both seniors and service delivery agencies. The members focus on building the capacity of the non-profit organization (partner) to overcome situations of unmet needs that lead to the degradation of desired lifestyle, the

lack of mobility, the inability to maintain independent living, and the threat of poverty for the senior citizen community.

AmeriCorps*NCCC

AmeriCorps*NCCC is a 10-month residential national service program for young women and men between the ages of 18 - 24. Members live at one of five regional campuses located throughout the country, and serve on teams to complete projects addressing the environment, education, public safety, and disaster relief. Teams meet these and other community needs in cooperation with non-profit programs, state and local agencies, and other community groups.

Since its inception in 1994, AmeriCorps*NCCC has worked with and assisted senior citizens though its service projects. Teams of Corps Members have delivered food and other goods to low-income elderly, helped repair homes and make them handicap accessible, assisted with respite care programs, and provided technical assistance to seniors filing their income taxes in order to receive the Earned Income Tax Credit. To date in 2003, the NCCC has supported over 2,400 senior citizens.

The Benefits of AmeriCorps Placement for Aging Americans

Below are some comments from seniors who have served as AmeriCorps members:

- **Michael Monroe**

"I joined an AmeriCorps*National program site as a mentor at the age of 87. As a widower and retired business executive, I knew I had a lot to give. AmeriCorps has been a rewarding way to bring joy to the community and to my own life.

For my first project, I became certified to assist seniors in understanding their health insurance supplements. Having someone there to help work through problems has made a great difference for people. I've also had great fun doing things like leading the singing of old songs at a retirement home and giving flu shots to other older individuals. With so many opportunities to become involved, I find my biggest challenge is organizing my time!

For me, service through AmeriCorps has been a labor of love. I plan to be a supporter of AmeriCorps for the rest of my life."

- **Dr. Charles Knox**

"I joined the VISTA program for the first time in 1966.

I moved from Wisconsin to Iowa to spend a year as a VISTA member serving in the area of community development and approaching issues like welfare rights and education. More than 30 years later I joined again, this time in Chicago, after an extensive career as

a student, teacher, scholar, and advocate for the socially disadvantaged. I've partnered with a variety of community members and faith-based organizations, and am proud to continue to assist in providing innovative services for the community.

An AmeriCorps*VISTA member must have a special blend of integrity, sincerity, compassion, and willingness to risk being a lifelong learner. Despite my years of experience, I'm still tested by new situations and enduring attitudes. Giving of myself, suspending judgment, and accepting people as they are have been my biggest hurdles. Our role isn't to *do*, it's to *teach* and help people improve their own lives. This is a gift, and it's one that I challenge us all to give."

- **Mary Ellen Mallonee**

"I was a Senior Attorney with the Federal Deposit Insurance Corporation; when the office closed in 1998 I retired, but was not ready to stop working. The experience made me appreciate my unique gifts and gave me a greater awareness of my talents. It's been a chance to participate in life and appreciate my gifts and talents. I've learned to trust my gut reactions in developing programs and working with the community."

Learn & Serve America

Overview

Learn and Serve America (LSA) supports service-learning programs in schools, colleges, and community organizations that engage more than 1 million youth in addressing education, public safety, environmental, and other human needs. Funds are used to create new programs or replicate existing programs, as well as to provide training and development to staff, faculty, and volunteers. Learn and Serve America projects are required to match federal funds with resources from the community.

LSA & Aging Americans

As one of the Corporation for National Service's three main programs, LSA works with seniors in a number of ways. In particular, many LSA sites partner with Senior Corps programs. Of LSA's 1,500 local programs, a significant number worked with Senior Corps programs and with senior-related issues in 2000-2001. (See Table A and Table B.)

Table A: National Snapshot of the Learn and Serve America local programs working with Senior Corps Programs*

Program	Number of Local Projects
FGP	62
RSVP	117
SCP	25
Total	**204**

Table B: National Snapshot of the Learn and Serve America local programs working with seniors issues by topic and setting*

Program Topic	Number of Local Projects

Human Needs: Elder Care	521
Senior / Eldercare Facilities	117
Total	**638**

* Source LSA data: this data was drawn from Learn and Serve America subgrantee information forms from 2000-2001 (most recent available), as reported to the National Service-Learning Clearinghouse, under contract to LSA. N = 1,538 local programs reporting.

Specifically, senior volunteers work with schools, after-school programs, community-based organizations and others to support student service and service-learning activities, especially those linked to lessons on civic skills, character and responsibility, and academic skills and knowledge.

There are a wide range of possibilities for what senior volunteers can do to help engage young people in service-learning and youth service opportunities:

- Assist with program administrative duties (prepare reports, fundraising).
- Establish and maintain community/school relations, prepare promotional materials.
- Assist teachers with integration of service-learning into the curriculum and other school programs.
- Facilitate student reflections.
- Coordinate the logistics of service projects.
- Assist by sharing specific content knowledge and skills (gardening, quilting, etc.) with teachers and students.

Here are a few examples of senior involvement in LSA programs:

- **Clemson Extension Service: Bringing Recreation for Intergenerational Community**

Clemson Extension Service's BR4IC (Bringing Recreation for intergenerational Communities) involved four counties with many different service projects. Each community planned for a community garden and beautification project. Youth and seniors planned and planted the garden. Then they harvested the contents and gave them

to the sick and shut-ins. All four counties had youth and seniors working on several other projects like sewing, making crafts, quilting, cooking, and baking 'simple gifts' for Alzheimer's patients' special events during Halloween, Thanksgiving, Christmas, and Valentine's Day.

- **Project SHINE (Students Helping In the Naturalization of Elders)**

Project SHINE linked college students with immigrants over the age of 50 who were seeking to learn English as a second language, increase their participation in the community and/or wished to become U.S. citizens. As part of a service-learning course, the college students linked to elder learners through the School of Continuing Education and provided them with 20 hours of tutoring.

- **Intergenerational Oral History/Community Studies Project**

High school students, teachers, elder mentors, and project partners joined forces to gather photographs, maps and conduct oral histories that document the community histories of the diverse neighborhoods that compose Miami Dade County. These resources were then placed on websites, videographed and donated to local historical archives for the broader community to view.

- **SaYES Program (Seniors Assisting Youth Engaged in Service)**

On August 31, 2002, President George W. Bush called on the Corporation for National and Community Service to dedicate the time and talents of 25,000 AmeriCorps members and Senior Corps volunteers to support student service activities and service-learning programs around the country.

SaYES is a joint initiative of Learn and Serve America and Senior Corps and was created in response to this call to action. It is administered by ETR Associates and managed by the State Education Agency Service-Learning Network and aims to:

- Bring much-needed help to local service-learning and youth service programs by increasing the number of Seniors (age 55 and older) volunteering in schools and community-based organizations to assist with carrying-out quality service-learning and youth service activities.

- Strengthen the existing support network for service-learning and youth service by establishing a system for the on-going recruitment and placement of Senior volunteers to assist in these activities.

- Identify and establish partnerships with new networks and organizations to promote service and service-learning volunteer opportunities to Seniors willing to serve.

- Compile and share widely best practices for recruiting and preparing Senior volunteers to assist in carrying out service-learning and youth service activities.

Summary

Through national and community service, citizens across the country are redefining their communities and strengthening the ties that bind us together. Aging Americans have long been actively involved in this process. Federal funding of national and community service remains a cost-effective way for America's older citizens to receive vital services, to use their skills and compassion for the benefit of others, and to strengthen their communities through the development of intergenerational connections.

The Corporation for National and Community Service is deeply committed to these goals. We believe that addressing seniors' needs and mobilizing their capacities will become increasingly important in the coming years, as the number of older Americans continues to expand. To this end, each of the Corporation's program streams (Senior Corps, AmeriCorps, and Learn & Serve America) provide distinct, locally-driven opportunities for seniors to benefit from national and community service. The Corporation is extremely proud to serve as the federal steward for these valuable interactions between seniors and their communities.

ITEM 15_EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

THE UNITED STATES
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

REPORT OF ACTIVITIES

ON BEHALF OF

OLDER AMERICANS

for

Calendar Years 2001 and 2002

The U.S. Equal Employment Opportunity Commission

INTRODUCTION

The U.S. Equal Employment Opportunity Commission (EEOC) is responsible for enforcing the Age Discrimination in Employment Act of 1967, 29 U.S.C. § 621 *et seq.* (ADEA). The following report details EEOC's activities on behalf of older Americans for calendar years 2001 and 2002. Within EEOC there are three major components through which the agency enforces the ADEA in the private sector: 1) the Office of Legal Counsel, 2) the Office of Field Programs, and 3) the Office of General Counsel. The report summarizes the regulatory and educational activities of these offices, as well as the ADEA administrative and litigation enforcement efforts undertaken by the Commission.

REGULATORY AND GUIDANCE

ACTIVITIES

OFFICE OF LEGAL COUNSEL

I. OVERVIEW OF THE OFFICE OF LEGAL COUNSEL

I. Mission

The Office of Legal Counsel is the Commission's principal legal and policy advisor. Its customers are the Commissioners, headquarters program offices, field offices, and stakeholders, *viz.*, those affected by Commission-enforced laws. The Office has three basic functions: (1) to promote inclusive workplaces by developing policy, reaching out to stakeholders, and providing legal advice about the federal employment discrimination statutes to promote voluntary compliance efforts; (2) to promote justice and opportunity by providing training and technical assistance to assure a sound and balanced enforcement program; and (3) to promote organizational excellence by serving as the Commission's legal advisor.

Policy guidance on the Age Discrimination in Employment Act of 1967 is provided by the Coordination and Guidance Services group, as described below.

II. Policy Development Functions

Coordination and Guidance Services (C&GS), provides policy direction and technical assistance on the Age Discrimination in Employment Act of 1967. C&GS operates under the direction of an Associate Legal Counsel and performs the following Commission functions:

- Administers the Commission's interagency coordination mandate under Executive Order 12067;
- Serves as the central locus for developing Commission policy under the Age Discrimination in Employment Act (ADEA) and all other EEOC-enforced statutes;
- Provides policy advice to the Commission, headquarters and field offices; and
- Provides advice to the public in response to written and oral requests, and through public presentations.

C&GS drafts a range of policy documents for the Commission, including:

- **Regulations and Guidelines** which are generally applicable definitions of the ADEA's substantive and procedural requirements.
- **Compliance Manual and Enforcement Guidance documents** which explain generally how to interpret and apply the laws enforced by EEOC.

- **Formal Opinion Letters** which respond to requests from individuals seeking legal interpretations on which the individual requesters may rely as a defense to liability in future enforcement actions. Opinion letters are rarely issued, apply only to the requestor, and do not bind or protect the general public.

- **Commission Decisions** which apply and interpret the law in actual cases pending before the Commission.

- **Memoranda of Understanding** with other federal agencies which ensure consistent enforcement of the federal employment discrimination laws and to eliminate duplication of effort.

- **Informal memoranda, correspondence, and talking points** which advise the Commission, its staff, and members of the public about interpretations and application of the ADEA.

II. PROGRAM ACTIVITIES ON BEHALF OF OLDER AMERICANS

A. Regulations

Retiree Health Plans - On August 20, 2001 the Commission announced that it would reconsider its position that, unless the equal benefit/equal cost defense was satisfied, the ADEA could be violated by eliminating or reducing *retiree* health benefits when the *retiree* reaches age 65 and becomes eligible for Medicare or a State-sponsored retiree health benefits program. The Commission took the step because it had received comments from employer and labor groups to the effect that its position was exacerbating a general trend toward eliminating health benefits for retirees of all ages.

In July 2003, the Commission exercised its exemption authority under Section 9 of the ADEA and issued a proposed rule that would exempt from the ADEA the practice of coordinating employer-provided retiree health coverage with eligibility for Medicare or a State-sponsored retiree health benefits program. The proposed rule is intended to ensure that the application of the ADEA does not discourage employers from providing, or continuing to provide, health benefits to their younger retirees, who otherwise would have to obtain such coverage in the private individual marketplace at significant personal expense. Office of Legal Counsel staff are currently reviewing the comments.

The Commission's position on *employee* health benefits remains unchanged. An employer must offer to *current employees* who are 65 or over - - that is, who are at or over the age of eligibility for Medicare benefits - - the same health benefits, under the same conditions, that if offers to any current employee under the age of 65.

ADEA Procedural Regulations - In August 2002, the Commission published a Notice of Proposed Rulemaking implementing changes made to the ADEA statute of limitations by section 115 of the Civil Rights Act of 1991. The proposed rule deletes references to the two to three year statute of limitations and provides that, when it has terminated the processing of an age discrimination charge, the Commission will issue a notice that the right to file an ADEA lawsuit will expire in 90 days. The NPRM also would delete the list of ADEA referral agencies that are in the existing ADEA procedural rules. The list is now obsolete and unnecessary since almost all states now have laws prohibiting age discrimination. The regulation, however continues to provide that the Commission will refer age charges to appropriate state agencies.

B. Compliance Manual

Section on ADEA - In October of 2002 the Office of Legal Counsel began to develop a new compliance manual section covering a broad range of issues and topics that arise under the ADEA, including coverage, exemptions, and its application to every aspect of the employment relationship.

Section on Employee Benefits - On August 20, 2001 the Commission rescinded Section IV (B) [Health Insurance] of the Compliance Manual Chapter on "Employee Benefits." The Benefits section, issued in 2000, addressed issues related to discrimination in benefits under all of the statutes enforced by the Commission, with particular focus on issues arising under the ADEA.

The Commission rescinded the section of the Compliance Manual in order – as explained in the above discussion of the Retiree Health regulation – to study the ADEA implications of plans that eliminate or reduce employer-provided retiree health benefits when the retiree reaches age 65 so that the combined package of employer-provided and Medicare-provided benefits amounts to lesser health benefits than are afforded to retirees under age 65.

C. Interagency Coordination Efforts

Cash Balance Pension Plans - Commission staff from several EEOC offices continue to coordinate with the Department of Treasury, the Internal Revenue Service, and the Department of Labor to address issues related to employers' adoption of cash balance pension plans. In these plans, which have been growing in popularity in recent years, employers typically convert traditional defined benefit plans - plans that promise a specified benefit upon retirement, based on a formula derived by the employer - into defined benefit plans in which each employee has a hypothetical individual account. The amount of the benefit is based on hypothetical employer contributions to the hypothetical account, plus interest at a specified rate of return.

In October 2002, the Office of Legal Counsel reviewed a proposed Treasury regulation entitled: "Reductions of Accruals and Allocations Because of the Attainment of Any Age; Application of Nondiscrimination Cross-Testing Rules to Cash Balance Plans." The Office of Legal Counsel drafted the Chair's comments. The letter commented on a provision in the proposed rule that would allow employers to set opening account balances in a manner that, we believe, effectively gave younger employees an infusion into their pension benefit that was not given to older workers. The letter declined comment on the rule's proposed manner of measuring the rate of benefit accrual in cash balance plan or its treatment of any wear-away caused by a conversion to a cash balance plan because the proposal did not set forth the legal basis for those rules, and reserved the right to make such comments in the future.

Trends in Aging Workforce - The Office assisted the Department of Labor in preparing a response to a Questionnaire on U.S. Older Workers for the Organization for Economic Co-operation and Development.

D. Analysis and Advice

Emerging Issues Task Force - In an effort to better serve all of its stakeholders, OLC formed a task force in 2002 to track and research topics that raise novel, or unresolved issues under one or more of the statutes enforced by the Commission. One of the major issues concerns "trends relating to the aging workforce." A brief synopsis of research and statistics gathered on age discrimination follows.

EEOC Charge Statistics Under the ADEA

The number of ADEA charges has increased approximately 25 % between FY 1997 and FY 2002, from 15,785 to 19,921. In addition:

- ADEA hiring charges have increased by nearly 200% since FY 1999.
- ADEA harassment charges have increased 31.5% since FY 1999.
- ADEA discharge filings have risen 30% since FY 1999.

General Trends Relating to the Aging Workforce

America's Baby Boom generation – persons born between 1945 and 1964 – is fast approaching retirement age. Between 2010 and 2030, the over- 65 population is expected to swell by more than 70%. At the same time, there will be fewer qualified younger workers available to replace retiring workers because the United States experienced a declining birth rate between 1965 and 1985. Commission research demonstrates that while 100 workers supported 29 retirees in the year 2000, the same number of workers will have to support approximately 47 retirees by 2030. Such a shift in the mix of workers and retirees is likely to stress safety net systems such as Social Security and

Medicare. On the other hand, many aging baby boomers want or need to work into their "retirement years for a variety of reasons, including the need for health care, inadequate pensions, and personal fulfillment.

The Commission anticipates a significant increase in ADEA charges over the next several years. The Office of Legal Counsel is currently considering what role it can play in assisting older persons who want to work and employers who want to retain older workers, and in educating employees and employers in order to reduce the incidents of actual or perceived age discrimination.

E. LIAISON ACTIVITIES

Outreach- Staff of the Office of Legal Counsel engages in liaison activities with Members of Congress, the general public, employers, labor organizations, and other stakeholders. Specifically, during 2001 and 2002, staff met with several Members of Congress , the ABA Joint Committee on Employee Benefits, representatives of the American Federation of Teachers, representatives of the National Education Association and several other stakeholder groups regarding early retirement incentive programs under the ADEA. In 2001 and 2002 staff participated in panel discussions and conducted several tele-conferences with various law firms on the ADEA/OWBPA tender back rule.

FEPA- Office of Legal Counsel staff annually prepare and update a case law manual for the FEPAs, consisting of over 300 pages of summaries of cases addressing major issues under the ADEA and the other laws enforced by the Commission. OLC staff also makes an annual presentation at the Annual Conference of FEPA Directors.

Correspondence- Commission staff routinely prepare written responses to inquires, including Congressional and White House requests, on various subjects under the ADEA.

III. COMMISSION WIDE PROACTIVE PREVENTION

The Commission believes that one of the best ways to eradicate employment discrimination in the workplace is through "proactive prevention." In fiscal years 2001- 02 (October 2000 - September 2002), under all the statutes EEOC enforces, the Commission conducted a total of 7,369 outreach, education, and technical assistance activities, reaching 618,156 individuals. These activities and events are designed to provide information and educational services to EEOC's broad range of stakeholders and to foster on-going relationships with individuals and organizations who share the common goal of ensuring equal employment opportunity in the workplace.

- Regarding the ADEA specifically, both EEOC headquarters and field offices conduct outreach, training and technical assistance on age discrimination issues, such as retirement benefits, to a wide variety of employer, advocacy, legal and

general audiences. During FYs 2001-02, the ADEA and related age discrimination issues were topics at over 388 events. Additionally, an overview of the laws enforced by EEOC was the topic at over 3,500 events, all of which included a discussion in some form of the ADEA.

- As an example of the Commission's ADEA-related outreach and education efforts, staff participated in a one-hour cable television program directed to viewers age 50 and older. The presentation provided an overview of the ADEA and the protections provided to persons in the protected group concerning employment matters.

- The Commission also provides fee-based training to private employers and government agencies through its Technical Assistance and Training Revolving Fund. Full day Technical Assistance Program Seminars (TAPS), on-site training and sign-up courses are offered. Most attendees are Human Resources or EEO personnel. In FYs 2001-02, more than 100 full-day Taps seminars were held and information on the ADEA was presented as part of the overview on EEOC procedures and updates on EEO law at nearly every TAPS.

ADMINISTRATIVE ENFORCEMENT

ACTIVITIES

OFFICE OF FIELD PROGRAMS

IV. OVERVIEW OF THE OFFICE OF FIELD PROGRAMS

A. Mission

The Office of Field Programs (OFP) oversees the EEOC's private sector programs of administrative enforcement of statutes prohibiting discrimination in employment, including the Age Discrimination in Employment Act. The Office provides overall direction, coordination, leadership and support to the administrative enforcement activities in 24 District Offices, the Washington Field Office and 26 Area and Local Offices

B. Functions

The Office is responsible for the following functions:

- Makes recommendations for Commission policy related to the implementation of the laws the Commission enforces and translates substantive policy into operational form through development of procedures and manuals for guidance to the field staff.
- Develops and provides guidance, advice, technical assistance, and education for the field, other headquarters offices and members of the public on EEOC's administrative enforcement process and the laws EEOC enforces. Coordinates these activities with pertinent headquarters offices.
- In conjunction with field offices, develops operational plans and budgets and implements approved plans relevant to: EEO charge resolution processes for Title VII of the Civil Rights Act of 1964, as amended (Title VII); the Equal Pay Act of 1963 (EPA); the Age Discrimination in Employment Act of 1967, as amended (ADEA); and the Americans with Disabilities Act (ADA).
- Coordinates with other headquarters and field offices to ensure the development, implementation and maintenance of appropriate systems that result in effective and efficient management of the Commission's charge resolution programs.
- Administers programs with the state and local Fair Employment Practices Agencies (FEPAs) and Tribal Employment Rights Organizations (TEROs).
- Coordinates with the Office of General Counsel to assure the effective integration of the investigative and legal staff activities in all aspects of the enforcement program.
- Develops and administers substantive staff development programs for managers and employees.

- Coordinates with the Office of the Chief Financial Officer and Administrative Services (OCFOAS) to assure efficient delivery of budgetary and general administrative services to field offices.

- Manages and coordinates the Commission's administrative enforcement Alternative Dispute Resolution (ADR) program and provides support and technical assistance for the program.

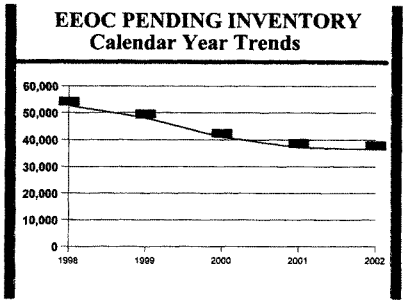
- Manages the Revolving Fund for technical assistance programs in coordination with appropriate Commission offices.

- Directs and supervises all aspects of field office administrative enforcement operations.

C. Policy Framework for Enforcement Activities

During 2001 and 2002, field offices continued implementation of the agency's National Enforcement Plan (NEP), the Commission's framework for policy priorities ratified in 1996. The NEP applies a three-pronged approach for addressing the agency's mission: (1) prevention of discrimination through enhanced education, technical assistance and outreach to the employer community, advocacy groups and other stakeholders; (2) the eradication of discrimination through investigation, conciliation, and litigation of charges with significant impact; and (3) effective caseload and inventory management, including use of Alternative Dispute Resolution methods, to allow the Commission to focus substantial resources on those matters having the greatest impact.

In addition, under the leadership of Chair Cari M. Dominguez, EEOC implemented a Five-Point Plan, which provides the framework for accomplishing our agency's mission with a coordinated, innovative and results-oriented focus. One of the Five Points is the Strategic Enforcement and Litigation component, by which EEOC will continue to address illegal discrimination through coordinated enforcement and focused litigation that ensures that we deploy agency resources wisely and effectively. The Chair established a Strategic Enforcement and Litigation approach, which has as its focus the development of baseline information on enforcement and litigation activities; the analysis and consideration of workplace trends, national and local issues, and industry information; and the utilization of other tools to enhance our efforts to remedy discrimination in the workplace.



As part of this effort, a cohesive, coordinated set of national enforcement and litigation strategies was developed to mesh the Commission's policy directions and support the Commission's mission. Included among these steps was the issuance of guidance from Chair Dominguez which set forth the principle that litigation, mediation and conciliation were all essential parts of the Commission's enforcement arsenal. The Chair urged field staff to be strategic in choosing the best way to approach each case and to do so through teamwork. To augment this effort for a long-term planning approach to the agency's enforcement and litigation, a separate analysis was conducted to identify emerging issues in the field of employment discrimination, so that the agency will be well-positioned to address issues likely to arise in the future. Additionally standards were developed for the District Directors and Regional Attorneys to use to identify charges, before and after cause findings, that would be appropriate for mediation and to assist them in balancing ADR, conciliation and litigation. Under the SELP, the expanded use of mediation and other ADR methods is encouraged, particularly as resolutions through mediation and conciliation are not only an effective method for achieving EEOC's mission, but are often completed cheaper, faster and better.

Other steps taken include the issuance of additional guidance to the District Directors and Regional Attorneys on working more closely and cooperatively in processing and resolving charges more expeditiously and effectively as a team. The EEOC continues to espouse the integral aspect in all of its activities of the importance of the close collaboration between investigators and attorneys in providing effective outreach, education and technical assistance, faster and more effective resolution of charges, and vigorous enforcement of the law when employers fail to take voluntary action.

Field offices addressed another key element of the Chair's Five Point Plan–Proactive Prevention, which emphasizes that the best way to combat discrimination is to prevent it from happening in the first place. In 2001 and 2002, field offices conducted outreach to a variety of audiences, including underserved populations, partnered with a range of stakeholder organizations and others, including state and local Fair Employment Practices Agencies, and promoted the agency's Freedom to Compete Initiative as well as the administration's New Freedom Initiative.

To further the Five-Point Plan element to "Promote and Expand Mediation," field offices negotiated more Universal Agreements to Mediate with employers, began analyzing the reasons behind the low Respondent participation rate, and expanded the range of cases eligible for mediation. Through these efforts, the agency continues to see increases in the number of charges resolved through our mediation program, with 1,535 resolved in 2002.

By the end of FY 2002, through the above described efforts, coupled with the continued use of the Priority Charge Handling Procedures (PCHP), the agency realized tremendous gains in reducing its charge inventory. Prior to implementation of the PCHP in June of 1995, the agency had a pending inventory of 111,451 charges. At the end of the 2002 calendar year, the inventory stood at 36,452, an incredible 67% reduction. These achievements were made through the continued focus on closing non-meritorious charges from the inventory as quickly as possible, referring the majority of charges first to mediation, and focusing investigations on the development of Category "A" charges–those with the highest likelihood of violations or significant impact on deterring or eradicating discrimination. Through these efforts, the agency's workload in 2002 involved more complex charges requiring a highly skilled and better trained workforce, as virtually no non-meritorious charges remained in the inventory.

The major trends in EEOC's overall enforcement activity during 2001 and 2002 are reflected in enforcement of the ADEA. These trends include significant reduction of the agency's pending charge inventory, reduction in charge processing time, an increase in settlements and in monetary benefits for charging parties, increased use of mediation to resolve charges, and expanded outreach and educational activity.

V. Highlights of ADEA Administrative Enforcement Activity

Major achievements during these two years included:

- **Continued increase in ADEA resolutions**. At the end of 2002, the agency resolved 22,489 ADEA charges, which were 24% of the total resolutions for the year and reflected an increase over the 18,053 ADEA resolutions in 2001.

- **Reduction in the age of charges in the pending inventory.** At the end of 2000, the average ADEA charge in the inventory was 199 days old. By the end of 2002, the average age had been reduced to 150 days.

- **Reduction of the time required to resolve cases.** Average processing time for ADEA charges was reduced by 47 days–from 191 days at the end of 2000 to 144 days at the end of 2002

- **An increase in mediated charges also dramatically reduced the time for resolving charges.** The average processing time for mediated ADEA charges in 2002 was only 111 days, compared to 144 days for ADEA charges resolved through other means.

A. Charge Receipts

In 2001, the Commission received 16,515 ADEA charges, representing 21% of the 79,758 charges received under all statutes that year. Approximately 60% of the ADEA charges also alleged discrimination under another **statute** enforced by the Commission (e.g. discrimination based on sex, disability, race).

In 2002, 22,798 ADEA charges were received (26% of total charge receipts). Slightly less than half of those charges also alleged discrimination under another Commission statute.

B. Discrimination Issues

Discriminatory discharge was by far the most frequent issue in ADEA charges (46% of all charges in 2001 and 39% in 2002). This is consistent with experience under all Commission statutes. Other significant ADEA issues, in order of frequency, were: Hiring; Terms and Conditions of Employment; Harassment; Seniority; and Promotion.

C. Charge Resolutions

The Commission resolved 18,053 ADEA charges in 2001, comprising 20% of all charge resolutions for the year. In 2002, there were 22,489 ADEA resolutions – 24% of total resolutions for the year.

D. FEPA Receipts and Resolutions

The Commission has dual filing agreements with state and local fair employment practices agencies (FEPAs) who process charges filed under the ADEA and laws they enforce. These agencies received 11,724 ADEA charges in 2001 and resolved 9,579 charges. In 2002, FEPAs received 11,300 ADEA charges and resolved 10,444.

E. Monetary Benefits

In 2001, EEOC obtained total monetary benefits of $75 million under the ADEA for 1,933 individuals, through settlements, conciliations and withdrawals with benefits. The average benefit per ADEA charge was $40,952.

In 2002, total ADEA monetary benefits of $68 million were obtained for 2,384 persons. The average ADEA benefit per charge was $31,697.

EEOC AND FEPA CHARGE ACTIVITY

	EEOC			FEPA		
	2000	2001	2002	2000	2001	2002
Total Receipts	81,007	79,758	87,167	59,288	64,327	64,738
ADEA Receipts	17,070	16,515	22,798	9,847	11,724	11,300
Total Resolutions	92,054	90,037	95,267	55,476	55,444	59,470
ADEA Resolutions	18,533	18,053	22,489	8,987	9,579	10,444
Total Benefits*	$247,000,000	$259,000,000	$254,000,000	$62,000,000	$87,,000,000	$72,000,000
ADEA Benefits	$56,000,000	$75,000,000	$68,000,000	$12,000,000	$15,000,000	$12,000,000

*Benefits rounded to nearest million.

F. Mediation Accomplishments

The centerpiece of the Chair's Five Point Plan is to promote and expand the use of mediation and other types of alternative dispute resolution (ADR). During 2002, the Commission established several initiatives to increase the use of mediation and other types of ADR in private sector charge processing and in the federal sector complaint process. The agency expanded the types of charges eligible for mediation to include Category A charges under the Priority Charge Handling Procedures (PCHP). Criteria were also developed to identify charges that would be appropriate for mediation at the conciliation stage after issuance of a determination of reasonable cause.

EEOC also established several initiatives to promote mediation with the employer community and to increase employer participation rates. The agency conducted increased outreach to the business and employer community, at both the field and headquarters levels, to encourage greater participation in the mediation program when a charge is filed. EEOC partnered with local chapters of employer associations, such as Chambers of Commerce, Small Business Development Centers, the Society for Human Resource Managers (SHRM) and local bar associations to reach employers and their legal representatives.

The Commission also emphasized and encouraged field offices to enter into universal agreements to mediate (UAMs) with local employers to facilitate their participation. The UAMs provide employers with the opportunity to mediate all appropriate charges filed with the Commission. By 2002, the agency had over 100 agreements that were entered into locally between employers and our District Offices. At the national level, three large corporations entered into national agreements to mediate all appropriate charges filed with EEOC at any of our District Offices across the country.

The Five Point Plan also called for the development of an objective, qualitative evaluation survey tool for mediation participants. In 2001, surveys completed in the previous year were analyzed by independent researchers who reviewed mediator responses regarding effective strategies in the mediation setting. A second survey, developed in 2002, was designed to examine the reasons Respondents accept or decline to participate in the EEOC's mediation program.

The agency also began efforts to establish a pilot program to suspend charge processing so that the parties may use a voluntary, employer-provided ADR program. The program was developed in 2002 and slated for implementation in early 2003 after a review of potential employers interested in participating in the program.

The mediation program continues to be a tremendous success and important component of the agency's enforcement efforts. Mediations of ADEA charges significantly increased from 1,335 in 2000 to1,535 in 2002. Total monetary benefits in ADEA mediated cases rose from $26.6 million in 2000 to $30.8 million in 2002. The average monetary benefit in 2002 ADEA mediated cases was $23,129.

Most significantly, the average resolution time from charge filing to final resolution was much shorter for mediated cases. In 2002, the average time for ADEA mediated cases was 111 days compared to an average of 144 days for all ADEA charge resolutions.

G. Examples of ADEA Mediated Resolutions

- A charging party alleged he was the victim of discrimination because of age and disability (heart condition) when he was discharged from his position as a manager for his employer's truck accessory business. The mediated settlement

included $11,000 in compensatory damages, the employer clearing the charging party's record of any derogatory information, showing that the Charging Party's position was eliminated and he was laid off for lack of work, that the employer would provide a neutral reference to any prospective employer, and that the employer would not contest the charging party continuing to receive unemployment benefits. Notably, this charge was resolved within 35 days of the filing of the charge.

- The agency successfully mediated an ADEA case filed by a 55-year-old female, who was working as an accountant in a large multi-organizational company. She had been notified that a new employee would be coming on board as her replacement and was told that she was not budgeted for in the following year, however, there had been no indication of an adverse employment action. The mediated settlement included $178,000 for the charging party, attorney fees and a provision for the charging party's continued employment for the next five years with no retaliation, and a review by corporate headquarters of any adverse action taken against the employee.

- An ADEA case was successfully mediated which involved a charging party, age 49, who alleged that he was not considered for job openings at a new facility which opened several months after his facility closed. Except for two employees eligible to retire, he was the only employee from the closed facility who was not given an employment offer at the new facility, or in another city. The terms of the mediated agreement included $199,500 for the charging party, in addition to the employer agreeing to provide a neutral reference.

H. Other Examples of ADEA Administrative Charge Resolutions

The following is a sampling of other non-mediated resolutions of age discrimination charges in EEOC field offices during 2001 and 2002. Consistent with the agency Priority Charge Handling Procedures (PCHP), national enforcement plans and the Strategic Enforcement and Litigation emphasis, innovative strategies and techniques were frequently utilized in the processing and resolution of these charges.

- The *Atlanta District Office* successfully settled an ADEA charge against a major financial and accounting corporation for $227,500 in actual monetary benefits and another $780,000 in projected monetary benefits. The Charging Party alleged that after more than 17 years of employment, he was forced to resign his partnership position because of his age (52). The negotiated settlement agreement included a provision that the employer eliminated its "non-compete clause" which allowed the Charging Party to go into business for himself or do the same type of work for another firm.

- The *Baltimore District* investigated a charge filed by a charging party who alleged he was not hired based on his age. Upon concluding its investigation, the District Office issued a cause determination and the case was successfully conciliated, resulting in monetary relief for the charging party of $12,500.

- The *Boston Office* successfully negotiated a settlement agreement for $85,000 involving a charging party, age 46, who was terminated as a salesman and replaced by a 23-year-old. The investigation revealed that the employer had wanted younger persons and that a manager had made a direct statement to this affect. The employer had claimed the charging party was terminated due to performance but there was no documentary evidence supporting this.

- The *Houston District Office* issued a cause determination after their investigation of an ADEA charge alleging discriminatory hiring and a violation of record keeping requirements. The charging party alleged employment discrimination based on her age, 63, when she was denied employment as a Manufacturing Team Member, but had over 30 years of related experience in a soldering and an assembly environment. The employer contented that the charging party did not pass the soldering test and she was fraternizing with an employee of the company during the testing period, however the investigation proved otherwise. The case was successfully conciliated for $20,000 back pay and compensatory damages, compliance with record keeping, and training for hiring officials.

- The *Indianapolis District* investigated charges filed by two individuals who alleged they were discriminated against based on their ages, 50 and 43 respectively, when they were discharged from their positions as production workers in the plastics industry. The investigation disclosed that the charging parties had been given warnings about their production and had been given 30 days in which to improve. The employer claimed they were discharged when they did not bring their production up to standard after 30 days, however, the investigation determined there were not any formal production standards in place. The charges were resolved with each charging party receiving $17,000 (equal to approximately one year's wages), a letter of reference and the expungement of their personnel records.

- The *New Orleans District Office* handled a charge in which the charging party alleged that he was disciplined and laid off because of his age in violation of the ADEA. The charge was resolved through a withdrawal with settlement, which resulted in a monetary award to the charging party in the amount of $72,000.

- The *Phoenix District* handled a case involving a charging party who was discharged one day after starting a job as a van driver and who alleged that the discharge was due to his age and disability, both of which were revealed in his job

application in response to unlawful questions. During the investigation, four additional charges were filed by individuals who were denied hire for the same reasons and an additional seven people were identified who did not want to file charges. These charges are particularly noteworthy because they are from northern Arizona, an underserved area where the district office had concentrated outreach and education efforts. The conciliation agreement not only resulted in monetary relief, including back pay and compensatory damages for all class members as well as the rehire of one charging party, but the employer also agreed to remove unlawful questions from its employment application; revise and redistribute its anti-discrimination policy in over 30 locations nationwide; provide training on the ADA and ADEA to all managers and supervisors; and submit its first EEO-1 report, despite that its size does not require the filing.

- The *St. Louis District* initiated a nationwide class investigation as a result of information received that the employer failed to hire and recruit persons who are age 40 or older in positions such as managers, brand representatives (retail sales), and stockers. The investigation disclosed that out of 16,000 employees in approximately 250 store nationwide, less than 50 (3/10 of 1%) were age 40 or older. Based on testimony from applicants and employees, review of applications, analysis of applicant flow data as well as other factors, the District Office found reasonable cause to believe that the employer failed to hire and recruit persons 40 years of age and older. A nationwide settlement was negotiated under which the employer agreed to place advertisements on a quarterly basis in major metropolitan newspapers publicizing employment opportunities within the respective store region, as well as national job postings in an AARP publications quarterly. The company also agreed to continue its effort to train all current store managers as well as newly hired or newly promoted store managers with respect to its EEO policy and to its commitment to hiring qualified individuals for retail store positions regardless of age or other protected status.

- The *San Antonio* office began an investigation of a charge in which the charging party alleged that because of her sex and her age (57), she was to be discharged as Quality Assurance Manager and was to be replaced by two males under the age of 40. The charge was resolved as a withdrawal with benefits for $205,000 and an additional $325,000 in projected monetary benefits over the next five years.

I. Cash Balance Plans

Utilizing the task force the agency established in FY 1999, comprised of EEOC experts, we continued to address the issue of whether older workers who are closer to retirement are discriminated against on the basis of age when employers convert from traditional pension plans to cash balance plans, which may reduce the expected retirement benefits of older workers while increasing the benefits allotted to younger workers. The taskforce continued its facilitation on

the matter with other federal agencies having authority over pension plans, such as the Departments of Treasury and Labor and the Internal Revenue Service. As of year end 2002, the agency had received 935 charges challenging the legality of cash balance pension plans.

J. Outreach, Education and Technical Assistance

EEOC outreach, education and technical assistance continued to expand during 2001 and 2002. During these two years combined, EEOC staff participated in more than 7,494 outreach, education and technical assistance activities reaching more than 611,965 persons. These activities included speeches, workshops, training seminars, representing EEOC at events of other organizations, and dissemination of informational materials.

During calendar years 2001 and 2002, the Commission participated in 79 educational, training and outreach events that specifically addressed the issues and concerns of older workers. Over 1,600 older workers attended these events. The Commission also provided information concerning the Age Discrimination in Employment Act (ADEA), including involuntary retirement, early retirement incentives, pension benefits, and waivers of ADEA rights at an additional 407 events. In addition, the Commission made many media presentations - including radio and TV interviews, talk shows and press conferences - that provided substantive information on the ADEA to many thousands of stakeholders, including older workers.

EEOC also continued its contact with a broad range of stakeholders to obtain their views on issues and customer service. Field offices continued activities to obtain regular input and communication with employer, advocacy and community based organizations. Regular meetings, Advisory Councils and Task Forces brought EEOC information on stakeholder concerns and provided stakeholders with information on EEO law, policy and procedures.

- The *Detroit* office provided an overview of the laws enforced by the EEOC for the Michigan Hispanic Senior Citizens Coalition in Lansing.
- The *New Orleans* office staffed a booth at the Jefferson Parish Senior Citizens Exposition, responding to questions and distributing information on laws enforced by EEOC.
- EEOC offices made media presentations - including radio and TV interviews, talk shows and press conferences providing information on the ADEA. For example, the *Philadelphia* office made a presentation on a local cable program on the ADEA and answered questions from the commentator regarding age criteria in hiring considerations, forced lay-offs and reductions in pay for older workers, mandatory retirement and severance agreements with waiver clauses, as well as other topics of interest to older workers.

- Many offices, including *Albuquerque, Birmingham, Charlotte, Cleveland, Denver, Indianapolis, Memphis, Philadelphia* and *St. Louis*, continue to provide information and individual counseling to advocates for older workers and potential charging parties who are older workers, while conducting "expanded presence" activities, i.e., events in areas which have been identified as underserved. These events also include information and counseling for employers, especially small businesses, who may not be able to afford human resource staff, to educate them on their responsibilities under the ADEA, thus preventing discrimination from occurring in the first place. For example, the *St. Louis* office has implemented a "Small Business Direct Contact Program," disseminating information and answering questions "door-to-door" to businesses in under served areas.

- Many offices, including *Charlotte, Cleveland,* and *Detroit* continue to partner with advocacy groups such as the NAACP, the Urban League and the Hispanic/Latin Forum, as well as the United Auto Workers (UAW) to address the concerns of older workers.

- EEOC field offices continue to conduct stakeholder input activities with groups representing the interests of older workers to maintain ongoing contact with and to obtain input from this groups of stakeholders. Activities include advisory councils, open houses, community meetings/forums, town hall meetings, and regular stakeholder meetings.

- Several offices have also partnered with state and local government agencies to reach older worker groups. For example, the *Cleveland* office made a presentation on age discrimination in conjunction with an event sponsored by the Ohio Civil Rights Commission.

LITIGATION

ACTIVITIES

OFFICE OF GENERAL COUNSEL

VI. OVERVIEW OF THE OFFICE OF GENERAL COUNSEL

A. Mission

The Office of General Counsel (OGC) was established by the Equal Employment Opportunity Act of 1972, which amended Title VII of the Civil Rights Act of 1964 (Title VII) to provide for a General Counsel, appointed by the President and confirmed by the Senate, with responsibility for conducting the Commission's litigation program. Following transfer of enforcement functions from the U.S. Department of Labor to the Commission under a 1978 Presidential Reorganization Plan, the General Counsel was also vested with responsibility to conduct Commission litigation under the Equal Pay Act (EPA) and the Age Discrimination in Employment Act (ADEA). With the enactment of the Americans with Disabilities Act (ADA) in 1990, the General Counsel was granted responsibility for Commission litigation under the employment provisions of that statute (effective July 1992).

The mission of OGC is to conduct litigation on behalf of the Commission to obtain relief for victims of employment discrimination and to ensure compliance with the statutes that EEOC is charged with enforcing. Under Title VII and the ADA, OGC is empowered to bring suit against nongovernment employers with 15 or more employees. The General Counsel's authority under the ADEA (20 or more employees) and the EPA (no employee minimum) includes state and local governmental employers as well as private employers. Title VII, the ADA, and the ADEA also cover labor organizations and employment agencies, and the EPA prohibits labor organizations from attempting to cause an employer to violate the statute.

B. Responsibilities of the General Counsel

The General Counsel is responsible for managing, coordinating, and directing the Commission's enforcement litigation program. He or she also provides overall guidance and management to all the components of OGC, including 24 legal units located in field offices. In directing the litigation program, the General Counsel is responsible for developing litigation strategies designed to attain maximum compliance with federal laws prohibiting discrimination in employment. The General Counsel recommends cases for litigation to the Commission and approves other cases for filing under authority delegated to the General Counsel under the Commission's 1996 National Enforcement Plan. (The General Counsel has redelegated much of his delegated litigation authority to the Regional Attorneys in charge of the field legal units.) The General Counsel also reports regularly to the Commission on litigation activities, including issues raised in litigation which may affect Commission policy, and advises the Chair and Commissioners on litigation strategy, agency policies, and other matters affecting the enforcement of the statutes within the Commission's authority.

C. Field Legal Units

OGC has 24 legal units which conduct Commission litigation and provide legal advice and other support to the district office enforcement units, which are responsible for investigating charges of discrimination. Field attorney staff also participate in district office outreach efforts, and in most offices the legal unit is responsible for responding tyo Freedom of Information Act requests. Each district office legal unit is under the director of a Regional Attorney.* The Regional Attorney manages a district office staff of 1 to 2 supervisory trial attorneys, 5 to 15 trial attorneys, and support staff, and also manages trial attorneys and support staff stationed in area and local offices within the district.

VII. ADEA LITIGATION HIGHLIGHTS

A. Litigation Statistics

In Calendar Year (CY) 2001, the Commission filed 39 ADEA lawsuits. Twelve, or 30.8%, of these cases sought relief for multiple aggrieved individuals. Eight were filed under another statute concurrent with the ADEA. During the same time period, the Commission resolved 35 ADEA suits; 13, or 37%, sought relief for multiple aggrieved individuals and 5 were filed under another statute concurrent with the ADEA. Through these resolutions, the Commission obtained monetary benefits in 2001 in the amount of $12.1 million.

In CY 2002, the Commission filed 38 ADEA lawsuits. Thirteen, or 34%, sought relief for multiple aggrieved individuals and 5 were filed under another statute concurrent with the ADEA. During the same time period, the Commission resolved 27 ADEA suits; 9 or 33%, of which sought relief for multiple aggrieved individuals and 5 of which were filed under another statute concurrent with the ADEA. The Commission obtained monetary benefits in the amount of $7.92 million in 2002 from lawsuits containing ADEA claims.

B. Supreme Court ADEA Decisions

Swierkiewicz v. Sorema N.A., 534 U.S. 506 (S. Ct. February 26, 2002). Petitioner filed suit under Title VII and the ADEA alleging that respondent unlawfully terminated him based upon his age and national origin. Despite petitioner's satisfactory performance, respondent demoted him and transferred his duties to a less qualified and less experienced employee who was a French national and 16 years younger. After two years of continuing age and national origin discrimination, petitioner sought a separation package comparable to those offered other

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* There are legal units in 23 of the Commission's 24 district offices and in the Washington, DC Field Office. One district office, Albuquerque, is staffed by two trial attorneys and support staff who report to the Regional Attorney in charge of the Phoenix District Office. The attorneys in the Washington Field Office legal unit report to an Assistant General Counsel in OGC headquarters.

executives who were terminated. In response, respondent offered petitioner the choice of resigning without any benefits or being fired. The district court granted respondent's motion to dismiss under Fed. R. Civ. P. 12(b)(6) because petitioner failed to allege a prima facie case and the court of appeals upheld for the same reasons.

In a brief as *amicus curiae* filed jointly with the Solicitor General on November 16, 2001, the Commission argued that petitioner's complaint satisfies Fed. R. Civ. P. 8 because it identifies a claim for which relief could be granted and provides fair notice of the factual circumstances giving rise to the claim. The Supreme Court unanimously held that an employment discrimination complaint need not allege facts sufficient to establish a prima facie case of discrimination, but only needs to contain "a short and plain statement of the claim showing that the pleader is entitled to relief." The Court followed the analysis offered by the government in its brief as *amicus curiae* and explained that the prima facie case outlined in cases such as McDonnell Douglas Corp. v. Green is an evidentiary standard, not a pleading requirement. The framework cannot be applied at the pleading stage because the formulation of the prima facie requirements can vary depending on context and before "discovery has unearthed relevant facts and evidence, it may be difficult to define the precise formulation of the required prima facie case in a particular case." The Court also stressed that a heightened pleading requirement is inconsistent with Fed. R. of Civ. P. 8 which requires only a "'short and plain statement of the claim.'" Under the proper standards, petitioner's claim should not have been dismissed because his complaint alleged that he had been discharged because of his national origin and age and gave sufficient background facts to give respondent notice of "what petitioner's claims are and the grounds upon which they rest."

C. Significant Appellate and Amicus Briefs Filed

In 2001, the Commission filed nine briefs in ADEA cases on appeal, five in Commission cases and four as *amicus curiae*. In 2002, the Commission filed twelve briefs in ADEA cases, five in Commission cases and seven as *amicus curiae*. The following briefs were filed in calendar years 2001 and 2002 on significant issues under the ADEA.

EEOC v. Kentucky Retirement System, Nos. 00-5664 et al. (6th Cir. Brief as Appellee filed January 11, 2001). In this ADEA enforcement action against the Kentucky Retirement System and others (collectively, "Kentucky"), the EEOC claimed that Kentucky's disability retirement program for state employees discriminates against a class of individuals age 40 and older by denying disability retirement benefits to individuals over age 55 in hazardous positions and individuals over age 65 in non-hazardous positions and by paying lower disability retirement benefits to an older worker with the same earnings and years of service as a younger worker, solely because of his age on the date he becomes disabled. Each of the defendants moved to dismiss the EEOC's complaint on Tenth and Eleventh Amendments grounds, arguing that the government's suit to enforce the ADEA violates constitutional principles of state sovereignty and federalism. The district court denied the motions to dismiss and each defendant filed an interlocutory appeal. The appeals were consolidated by the Sixth Circuit.

Argued: On appeal, the Commission argued that the Eleventh Amendment does not shield a state from a suit by a federal government agency to enforce federal law and the Tenth Amendment does not limit Congress' authority under the Commerce Clause to require state employers to comply with the ADEA's prohibition against age discrimination in providing employment benefits to older workers.

Decided: 2001 WL 897433 (6th Cir. August 2, 2001) (unpublished). The Sixth Circuit affirmed the district court's decision, holding that Kentucky is not entitled to immunity on either Tenth or Eleventh Amendment grounds from the EEOC's suit seeking Kentucky's compliance with the ADEA and relief for persons injured by violations of the ADEA. The court of appeals held that "to the extent the EEOC seeks [Kentucky's] compliance with the ADEA, as well as relief on behalf of [charging party] Charles Lickteig and those similarly situated for ADEA violations, [Kentucky is] not entitled to immunity on either Tenth or Eleventh Amendment grounds." The Court reversed the denial of immunity only as to that portion of the EEOC's complaint that sought an order requiring Kentucky "to enact permanent legislation," and held that "forcing [Kentucky] to do so would violate the Tenth Amendment."

Kentucky petitioned for Supreme Court review.

EEOC v. Kentucky Retirement System, et al., No. 01-573 (U.S. Supreme Court Op. Cert. filed December 2001). The Commission argued that the petition for certiorari should be denied because the court of appeals' rejection of Kentucky's Tenth Amendment claim does not conflict with any decision of the Supreme Court or any other federal appellate court, and is particularly ill-suited for review in its current interlocutory posture. On January 7, 2002, the petition for review was denied. 534 U.S. 1079 (S. Ct. 2002).

Sepulveda v. Salt River Pima-Maricopa Indian Community/Phoenix Cement Company Division, No. 00-16358 (9th Cir. Brief as *Amicus Curiae* filed January 5, 2001) and **McCoy v. Salt River Pima-Maricopa Indian Community/Phoenix Cement Company Division**, No. 00-16389 (9th Cir. Brief as *Amicus Curiae* filed January 26, 2001). In these cases, the defendants moved for summary judgment, invoking the doctrine of tribal sovereign immunity to bar the Plaintiffs' claims of employment discrimination under Title VII and the ADEA. The district court denied summary judgment with respect to the Plaintiffs' employer. The court relied heavily on a 1996 Commission Decision which held that defendant was not entitled to the protection of Title VII's exemption for an "Indian tribe."

Argued: On appeal, the Commission argued as *amicus* that tribal sovereign immunity extends only to an Indian tribe, its governmental authorities and agencies, and those tribal businesses that qualify as subordinate economic organizations of the tribe. There are genuine issues of material fact precluding summary judgment on the immunity question. The 1996 Commission Decision does not address the issue of sovereign immunity but does provide support for statutory coverage, as do the decisions of the Ninth Circuit.

Lauderdale v. Johnston Industries, Inc., No. 01-12835-FF (11th Cir. Brief as *Amicus Curiae* filed August 9, 2001). In this private ADEA case, plaintiff alleged, inter alia, that defendant violated the ADEA by discharging him because of his age and then refusing to rehire him. The district court granted summary judgment to defendant on all of plaintiff's claims. The court dismissed the discharge claim on the ground that plaintiff had knowingly and voluntarily waived his right to challenge his discharge under the ADEA. The court held that a waiver cannot be invalidated merely because it was based on an employer's misrepresentation of the reasons for the discharge. The court dismissed plaintiff's rehire claim because he did not show that he applied for any new position at defendant and because, "insofar as he sought to be rehired to his old position, his claim is barred."

Argued: The Commission argued that a waiver induced by fraudulent misrepresentation is invalid under the Older Workers Benefit Protection Act (OWBPA) even if the misrepresentation goes to the employer's stated reason for the challenged employment action.

Decided: 2002 WL 338631 (11th Cir. February 7, 2002). Adopting the Commission's reasoning as *amicus curiae*, in an unpublished decision the Eleventh Circuit reversed the district court's grant of summary judgment dismissing the plaintiff's age discrimination claim on the ground that he had signed a valid waiver of his right to challenge his discharge. Noting that "a waiver procured by fraud may not be executed knowingly or voluntarily," the Eleventh Circuit ruled the plaintiff had shown the waiver was invalid through credible evidence that he had justifiably relied on defendant's misrepresentation in signing the release.

Robert H. Tice v. American Airlines, Inc., No. 01-3513 (7th Cir. Brief as *Amicus Curiae* filed November 13, 2001). The district court dismissed for lack of subject matter jurisdiction this private ADEA suit brought by a group of former pilots to challenge their mandatory retirement from American Airlines ("American"). The plaintiffs, who were disqualified by federal regulation from serving as a captain or co-captain once they reached age 60 (age-60 rule), were forced to retire because American refused to allow them to down-bid to the third cockpit position of flight officer, which carries no federal age restriction ("no down-bid rule"). The district court credited American's argument that the interpretation of a provision in the collective bargaining agreement ("CBA") between American and the pilots' union "would be dispositive of the plaintiffs' [ADEA] claims," and consequently held that their federal statutory claims were precluded by the Railway Labor Act ("RLA"), which requires exclusive and binding arbitration of claims arising under a CBA between an airline and its employees.

Argued: The district court erred in (1) holding that this ADEA suit was precluded by the Railway Labor Act and (2) dismissing for lack of subject matter jurisdiction because the retired pilots' federal statutory claim that American unlawfully denied their requests to down-bid to flight engineer jobs once the FAA's age-60 rule disqualified them from being captains states a cognizable claim of disparate treatment in violation of the ADEA that cannot be conclusively resolved through an interpretation of the CBA between the airline and the pilots' union.

Decided: 288 F.3d 313 (7th Cir. April 30, 2002). The Seventh Circuit modified the district court's order dismissing the plaintiffs' age discrimination claims. The court decided that the resolution of the plaintiffs' ADEA claims requires the interpretation of certain CBA provisions governing the rights of pilots to down-bid under American's seniority system, and that the RLA mandates arbitration as the exclusive means to resolve disputes over the meaning of CBA provisions. At the same time, the court recognized that the plaintiffs have a legally independent right to litigate their federal statutory claims of age discrimination and could maintain their ADEA suit if the CBA, as interpreted in RLA arbitration, does not establish an age-neutral down-bid policy. The court therefore "modified [the judgment] to convert the dismissal of the plaintiffs' [ADEA] suit to a stay of the suit pending referral of the parties' dispute to [RLA] arbitration," and remanded the case to the district court. If the arbitral resolution of the contractual dispute "does not resolve the issues in the suit," the Court ruled, "the suit can resume."

EEOC v. Board of Regents of the University of Wisconsin, No. 01-2998 (7th Cir. Brief as Appellee filed December 21, 2001). The Commission prevailed before a jury in this ADEA suit alleging that the University of Wisconsin violated the ADEA when it terminated the employment of four charging parties because of their age. UW appealed, arguing that the Commission's suit is barred by the Eleventh Amendment and that there was not sufficient evidence to support the jury's verdict.

Argued: The Commission argued that its suit is not barred by the Eleventh Amendment which is a bar to private lawsuits but does not apply to suits brought by an agency of the U.S. government. The Commission also argued that the evidence was sufficient to support the verdicts. The evidence shows that the written justification for the terminations is a post-hoc document riddled with factual errors that makes unfounded assumptions about the superior skills of the younger individuals retained at the Press and uses age-tainted code words in referring to the charging parties. There is also evidence that the two decision-makers misled UW officials about the facts purportedly supporting the terminations and that the decision-makers planned all along to hire replacements for the charging parties despite claiming at the time that the terminations were designed to cut costs by eliminating positions in the Press. The employees retained at the Press were all younger than the charging parties and a number of younger individuals were hired in the months immediately following the terminations into the very same departments that had been previously occupied by the charging parties.

Decided: 288 F.3d 296 (7th Cir. April 30, 2002). Rejecting UW's argument that the EEOC's claim for victim-specific relief was barred by the state's Eleventh Amendment sovereign immunity, the Seventh Circuit cited the "well-established principle that the fact that states retain sovereign immunity from private lawsuits [as they do under the ADEA] does not mean that they are protected from suit by the federal government." The court also found the evidence sufficient to support the jury's verdict of a willful violation of the ADEA and rejected UW's arguments for judgment as a matter of law and for a new trial.

SPARA v. DiFava, Nos. 01-1581 & 01-2429 (1st Cir. Brief as Appellee filed March 11, 2002). Before 1991, Massachusetts had state law enforcement officials in four different units: the Division of State Police was the main unit, but there were also three smaller units. State law required the officers in the Division to retire at 50 but allowed the officers in the three smaller units to work until 65. In 1991, Massachusetts consolidated the four units into one "Department of State Police" and required all officers to retire at 55. The Commission intervened in a suit challenging this policy and in June 1998, the district court entered a permanent injunction barring the Commonwealth from enforcing the challenged law. No one appealed.

In January 2001, SPARA, an association of younger officers who wanted the older officers to retire so they could get more promotions, sued three Commonwealth officials. They claimed that the injunction was invalid when entered (because it was overbroad and lacked a termination date) and in any event become invalid when the Supreme Court issued Kimel v. Florida Board of Regents in 2000, holding that individuals cannot recover damages in private ADEA actions against state governments because Congress had not properly waived their eleventh amendment immunity. The Commission and a group of older officers supporting the injunction intervened as defendants. The district court dismissed, holding that SPARA misinterpreted Kimel, and that SPARA's other claims are barred by res judicata and stare decisis. SPARA appealed.

Argued: On appeal, the Commission argued that in Kimel the Supreme Court held only that Congress, when it amended the ADEA to apply to the states, lacked the power under the Constitution to abrogate the states' sovereign immunity to individual actions for damages. EEOC v. Wyoming, which upheld the constitutionality of the ADEA as applied to states under a Tenth Amendment challenge, is still good law after Kimel. The states are obligated to obey the ADEA and they can be sued by the Commission and by individuals seeking prospective injunctive relief under Ex parte Young. The Commission also argued that these plaintiffs do not have a cause of action to challenge the prior injunction. They have no statutory cause of action. They claim an equal protection violation, but they do not state a viable equal protection claim, because: (i) they do not even show any differential treatment, let alone a suspect class; and (ii) they show no burden on any fundamental right. Finally, the Commission argued that the district court correctly ruled that SPARA's other claims are barred by res judicata and stare decisis.

EEOC v. Liberal R-II School District, Nos. 02-1025 & 02-1029 (8th Cir. Brief as Appellant filed March 11, 2002). George Trout worked as a school bus driver for the Liberal R-II School District for four years with no serious complaints about his job performance before the school board voted not to renew his contract. The school superintendent, who is the spokesperson for the district, told the State of Missouri, "The fact that Mr. Trout is now 70 ½ years of age and that the public had voiced concerns about his driving safety, his continuation as a bus driver for the coming school year was not approved by the Board of Education." The superintendent also told Trout that his employment was terminated because the board believed that he was too old to continue driving a bus. Just a few months later, when school resumed and additional drivers were needed to cover Trout's and other routes, the district hired three new drivers, ages 39, 41 and 43. In addition to the evidence of Trout's satisfactory performance as a bus driver, the

district's explanation for the decision evolved over the course of the Commission's investigation and this litigation. The district court granted summary judgment for the school district, holding that the Commission did not make out a prima facie case of age discrimination, and awarded fees to the defendant under the Equal Access to Justice Act, holding that the Commission's suit was not substantially justified.

Argued: On appeal, the Commission argued that statements by defendant's school superintendent (who was privy to the school board's deliberations and was charged with conveying the board's decision to the terminated employee) that the board's decision to terminate him was based on age, constitute direct evidence of age discrimination. Further, the Commission argued that even if that is not direct evidence, the evidence is sufficient to establish a prima facie case of discriminatory discharge where the defendant terminated a 70 year-old bus driver, with no disciplinary record, and immediately thereafter hired three new bus drivers each of whom was at least 27 years younger than he. Finally, the Commission argued that the district court erred in holding that subsection (d) of the Equal Access to Justice Act applies to ADEA actions, and that the Commission's case was not substantially justified.

Decided: 314 F.3d 920 (8th Cir. December 31, 2002). The Eighth Circuit reversed the district court's grant of summary judgment against the Commission and vacated the lower court's award of attorney's fees to the defendant. The court of appeals held that the defendant was not entitled to summary judgment because sufficient direct evidence of age discrimination existed to create an issue of material fact on the Commission's age claim. The court found that although the Superintendent was not the actual decision maker, he was closely involved in the decisionmaking process and was directed to express the decision of decision makers to the employee and to the Missouri Division of Employment Security. Based on the evidence of the Superintendent's statements, the court found that "[a] jury could reasonably infer the Board made age-based comments when making its decision and [the Superintendent] dutifully reported the Board's decision and reasons to Trout." The Superintendent had also made an age-based statement in writing in addition to the statement Trout alleged he made about him being too old to drive a bus. The court also agreed with the Commission that the record does not establish that the district would have made the decision to terminate Trout's contract even were age not a factor. Because the court of appeals analyzed the case under the direct evidence theory, it did not assess the evidence under the McDonnell Douglas standard. The court also vacated the award of attorney's fees without deciding whether the Equal Access to Justice Act's "substantially justified" standard applies to cases brought by the Commission under the ADEA because it found that the EEOC was substantially justified in bringing the action and the district is not a prevailing party.

Isbell v. Allstate Ins. Co., No. 01-cv-252 (S.D. Ill. Brief as *Amicus Curiae* filed April 26, 2002). Allstate Insurance Co. announced that it was terminating the "employment contracts" of all of its employee-agents. Agents who agreed to sign a waiver and release of claims could continue selling insurance but as independent contractors rather than as employees. Isbell, a veteran employee-agent, had a pending worker's compensation claim against Allstate and had also filed a

charge challenging the termination decision and release requirement. Unwilling to waive these claims, Isbell refused to sign the release and lost her job. She then sued Allstate, alleging a substantive ADEA claim and retaliation claims under all federal discrimination statutes as well as state law for the worker's compensation claim.

Argued: The Commission filed an *amicus* brief advancing two principal arguments. (1) Isbell engaged in protected activity when she refused to waive her discrimination claims. While the anti-retaliation provisions of Title VII, the ADEA and ADA do not expressly state that refusing to withdraw a discrimination charge and promising not to file one are protected activities, the logic of the sections and the Congressional purpose behind them strongly suggest that these activities are in fact protected. The Commission argued that since employers may not penalize employees for filing or threatening to file a charge, it would make no sense to hold that they may nevertheless penalize employees for refusing to withdraw a charge or refusing to promise not to file a charge. (2) To the extent Allstate fired Isbell for exercising her statutory rights (or refusing to waive her right to do so), it violated Title VII, the ADA and the ADEA. Allstate defends its conduct, arguing that it was not required to offer Isbell the independent-contractor position. On the contrary, as the Supreme Court noted in Hishon v. King & Spalding, 467 U.S. 69, 75 (1984), once an employer decides to offer a particular benefit or privilege to its employees, the federal discrimination statutes prohibit offering that benefit or privilege in a discriminatory or retaliatory manner.

Spinetti v. Service Corporation International, No. 01-4415 (3d Cir. Brief as *Amicus Curiae* filed June 3, 2002). Plaintiff Appellant Spinetti filed suit against Service Corporation International ("SCI") alleging she was fired because of age and gender discrimination and asserting claims under the ADEA and Title VII. SCI moved to compel Spinetti to arbitrate these claims based on a pre-dispute arbitration clause contained in a document that Spinetti was required to sign during her employment. SCI's arbitration program required employees to pay one-half the costs of the arbitration and required each party to pay its own attorneys fees, thereby barring a prevailing employee from an award of attorneys fees to which he or she would be entitled under federal civil rights statutes. When Spinetti objected to arbitrating her claims on these two grounds, SCI offered to waive the ban against an award of attorneys fees if Spinetti prevailed in the arbitration. The arbitration agreement, however, barred any modifications except by a written agreement to which both parties concurred. Invoking this provision, Spinetti declined to modify the arbitration agreement. The district court agreed with Spinetti that the cost-sharing requirement and the ban on an award of attorneys fees were both invalid. The district court nevertheless held that the arbitration agreement was enforceable with the objectionable provisions excised and ordered Spinetti to arbitrate her claims.

Argued: The district court properly held both the cost-sharing requirement and the prohibition against an award of attorneys fees invalid, but erred in enforcing the agreement with these invalid provisions excised. Public policy considerations require that courts refuse to enforce such agreements in their entirety in order to ensure that employers do not have an incentive to impose invalid arbitration provisions on their employees.

EEOC v. Sidley, Austin, Brown & Wood, No. 02-1605 (7th Cir. Brief as Appellee filed June 10, 2002). The Commission began a directed investigation of Sidley & Austin to ascertain whether the Fall 1999 demotions of 32 attorneys – from "partner" to "senior counsel" or "counsel" – and a change in the firm's mandatory retirement policy for partners violated the ADEA. Over several months, Sidley produced some of the information requested by the Commission, but refused to turn over other information on the ground that, in Sidley's view, it was not relevant to the question of whether Sidley partners are covered by the ADEA. The Commission issued a subpoena, and when Sidley refused to comply, filed a motion to compel enforcement. The subpoena sought information relevant both to the question of whether lawyers deemed "partners" are covered under the ADEA, and to the question of age discrimination. The district court granted the Commission's motion. The court held that Sidley had not shown that the facts on coverage were so clear that, in effect, Sidley should be entitled to judgment as a matter of law. Sidley appealed.

Argued: It would be premature to decide the question of coverage at the subpoena enforcement stage where the facts actually produced, and facts that have yet to be produced, could show that – considering the categories of remuneration, ownership, and management – some Sidley partners are more like employees than employers.

Decided: 2002 WL 31387525 (7th Cir. October 24, 2002). The Seventh Circuit agreed that the Commission was entitled to full compliance with that part of the subpoena relating to the coverage question. The court of appeals declined to order, at this stage of the proceedings, compliance with the part of the subpoena seeking merits-based information. After Sidley produces all coverage information, it will be required to produce the merits-based information unless the district court determines that it is plain on the basis of uncontested facts that the relevant partners are not covered by the ADEA. Judge Easterbrook concurred in the judgment stating that he thought it likely the 32 demoted lawyers were not covered but that he did not know, without further information, how other lawyers should be classified. The court squarely rejected the argument that the coverage question is a threshold jurisdictional issue and stated that the Commission "has the same right to obtain information bearing on its jurisdiction as to obtain any other information that it needs in order to decide whether there has been a violation of one of the laws that it enforces." On the coverage question, the court rejected the argument that all partners are employers and emphasized certain aspects of the law firm and its governance that undercut Sidley's contention that it had proved all 32 former partners were employers, namely that in a partnership of more than 500 partners, all power resides in a small, unelected committee of 36 members. The panel also noted that other attributes of Sidley partners – the ability of partners to commit the firm, participation by all partners in some administrative committees, compensation based in part on firm profits, some ownership of firm capital – might also be enjoyed by employees of corporations, thus undermining Sidley's argument that the 32 former partners were necessarily "employers" and not "employees." The court considered "[p]articularly unconvincing" Sidley's contention that the absolute power of the executive committee is not a factor pointing toward employee status because the committee's power is power delegated by the remainder of the partnership because "[t]hat would be like saying that if the people elect a person

to be dictator for life, the government is a democracy rather than a dictatorship." In this case, partners outside the executive committee "do not even elect the members of the committee. They have no control, direct or indirect, over its composition." On the other hand, the liability features of the partnership may militate against employee status. In this case, the court considered the coverage issue too "murky" to decide and ordered compliance with the subpoena requests for coverage information.

Wastak v. Lehigh Valley Health Network, No. 02-2111 (3d Cir. Brief as *Amicus Curiae* filed November 4, 2002). When he was fired, John Wastak signed a waiver as part of a separation agreement. That waiver released his ADEA claims and also prevented him from filing an age-discrimination charge with the EEOC. He ultimately filed a charge and brought suit. The district court dismissed his case, ruling that he had waived his ADEA claim. The court held that even if the charge-filing ban was unenforceable, it did not affect the rest of the ADEA waiver.

Argued: The Commission filed an *amicus* brief arguing that the court should not have enforced Wastak's waiver as to his ADEA claim. The ADEA requires that waivers be written in a manner calculated to be understood by the employee. Wastak's waiver, however, states that he may not file an age-discrimination charge even though his right to file an EEOC charge is protected by statute and cannot be waived. Thus, the waiver is misleading. Because the waiver is not written in a manner calculated to be understood by Wastak, it is not enforceable at all against an ADEA claim. The Commission also argued that enforcing Wastak's waiver would hinder the EEOC's efforts to eliminate age discrimination in the workplace. A charge-filing ban like the one in Wastak's waiver will deter many employees from exercising their right to file age-discrimination charges even if the ban is never enforced. Thus, merely striking the ban from the waiver and enforcing the rest would not protect the public interest in redressing age discrimination. Furthermore, the employer is responsible for drafting a waiver that fully complies with the ADEA, and there can be no argument that the Network harbored a good-faith belief that the charge-filing ban was valid.

Palasota v. Haggar Clothing Co., No. 02-10844 (5th Cir. Brief as *Amicus Curiae* filed December 18, 2002). Jimmy Palasota, a 51 year old employee at the time of his termination, was an outstanding Sales Associate at Haggar for 28 years. In the 1990s, Haggar's management felt that the company was not reaching the younger market and attempted to portray a younger image for the company, transferring the sales function that was previously performed by the Sales Associates to the younger Retail Marketing Associates. In addition to the transferring of job duties, management voiced concerns about the age of its sales staff (including the plaintiff). Palasota's employment was terminated on May 10, 1996. On January 24, 2002, a jury awarded Haggar $842,218.96 in back pay finding that Haggar had willfully discriminated against Palasota on the basis of age in violation of the ADEA. The district court granted Haggar's motion for judgment as a matter of law, however, and dismissed the case, thereby setting aside the jury's verdict. The court held that all of the age-related comments made by Haggar's management were "stray remarks" and therefore not "probative" of the company's discriminatory intent. The district court further concluded that Palasota's case failed because he did not show that Haggar

had given preferential treatment to a younger employee. Finally, the district court held that none of Palasota's other anecdotal evidence supported his discrimination claim.

Argued: The Commission argued as *amicus curiae* that the district court erred in holding that Palasota's case failed because he was unable to show that Haggar had given preferential treatment to a younger employee under "nearly identical" circumstances because establishing that a younger employee was given preferential treatment is only one of the ways in which a plaintiff may demonstrate age discrimination and is not a requirement of proving an ADEA claim. Moreover, the evidence rejected by the district court as irrelevant or not "probative" of age discrimination falls squarely within the categories of circumstantial evidence approved by the Supreme Court and is clearly sufficient to establish age discrimination in this case. Finally, contrary to Supreme Court and Fifth Circuit law, the court improperly disregarded the age related comments made by Palasota's superiors as "stray remarks" not probative of discrimination.

D. Significant District Court and Appellate Court Resolutions by Issue

1. Threshold Issues: Coverage and Standing

EEOC v. Karuk Tribe Housing Authority, 260 F.3d 1071 (9th Cir. August 12, 2001). The Ninth Circuit reversed the order enforcing the Commission's administrative subpoena under the ADEA against the Karuk Tribe Housing Authority. Although the court noted that the Housing Authority could not claim sovereign immunity in a suit by the Commission because tribes are not immune from suits brought by the federal government, it held that the Authority is not covered by the ADEA in this case. The court held that the Commission does not have regulatory authority over a tribal employer where it functions as an "arm of the tribal government" and the charging party belongs to the tribe. The court reasoned that the employment relationship between such an entity and a tribe member "touches exclusive rights of self-governance in purely intramural matters" and so is exempt from coverage under the ADEA. The court also held that it properly could reach this coverage question in a subpoena enforcement action because "the prejudice of subjecting the Tribe to a subpoena for which the agency does not have jurisdiction results in irreparable injury vis-a-vis the Tribe's sovereignty."

EEOC v. North Gibson School Corp., 266 F.3d 607 (7th Cir. September 11, 2001). In this ADEA action the Commission sought monetary and equitable relief for school teachers who had been subject to a discriminatory early retirement plan. The Seventh Circuit affirmed the district court's entry of summary judgment for North Gibson, holding that the EEOC lacked standing to obtain monetary relief because no timely discrimination charges had been filed–despite the fact that the ADEA does not require that Commission suits be based on a charge, timely or otherwise. The court also held that the Commission was not entitled to injunctive relief because there was no proof that the current early retirement plan was discriminatory or that the Commission had a reasonable expectation that a discriminatory plan would be adopted in the future.

Fogleman v. Mercy Hospital, Inc., 283 F.3d 561 (3d Cir. March 18, 2002). In this case, the plaintiff alleged unlawful retaliation under both the ADEA and the ADA. The plaintiff claimed that he was terminated from his job with the defendant because of the protected activity of his father, who also worked for the defendant. The district court granted summary judgment in favor of the defendant, holding, in part, that the anti-retaliation provisions of the ADEA and the ADA only protect an individual from retaliation when that individual himself has engaged in the protected activity. The Commission argued as *amicus curiae* that the anti-retaliation provisions cover third-party retaliation, but the court concluded that the plain language of the statutes does not support such an interpretation because the statutes forbid only "discrimination against an individual because 'such individual' has engaged in protected activity." Acknowledging that this narrow reading is at odds with the animating purposes of the anti-retaliation provisions, the court nonetheless concluded that its reading did not produce absurd results and that it therefore had to give effect to the literal meaning of the statute.

2. Waiver of Claims

EEOC v. Bull HN Information Systems, Inc. No. 97-11327-NG (D. Mass. May 29, 2001). The Commission alleged in this ADEA action, which was consolidated with actions filed by the Commonwealth of Massachusetts and an individual laid off by defendant in 1994, that in connection with a series of layoffs beginning in 1994, defendant, an advanced technology company, used releases that failed to comply with a number of the requirements in section 7(f) of the ADEA. The court granted partial summary judgment to EEOC and the Commonwealth, finding that the releases used by defendant from July 1994 to January 1998 violated the ADEA in a number of respects. The court reaffirmed its earlier ruling in the Commonwealth's suit (reported at 16 F. Supp. 2d 90, 105-07 (D. Mass. 1998)) that the ADEA authorizes independent actions challenging the validity of waivers but held that the individual plaintiff could not recover damages for a waiver violation. The court then found that the 300-day charge filing period in the ADEA did not limit the Commonwealth's and EEOC's ability to challenge the validity of releases regardless of the effect of that limitations period on suits by individuals.

The court held that the release used by defendant from July 1994 to July 1996 was invalid because defendant failed to provide the information required under section 7(f)(1)(H) of the ADEA and gave employees only 21 rather than 45 days to consider the release (section 7(f)(1)(F)(ii)). The court also found that both the July 1994 to July 1996 release and the release used from July 1996 to January 1998 were invalid under section 7(f)(4) because by prohibiting employees from bringing "claims" they interfered with employees' rights to file charges with the EEOC and to participate in EEOC investigations. The court said that issues of fact remained on whether 1 week of pay per year of service provided to employees in return for signing a release constituted sufficient consideration under section 7(f)(1)(D). This same benefits package was provided to employees laid off before institution of the release requirement in 1994 and the court said it would have to determine whether this prior conduct of defendant in connection with severance pay plans created an implied contract with employees *entitling* them to receive a week of pay per year of service.

3. Benefits

EEOC v. Hickman Mills Consolidated School, No. 98-1296-CV-W-3 (W.D. Mo. January 18, 2001). The Commission alleged in this ADEA action that the defendant, a school district, administered early retirement incentive plans that discriminated on the basis of age by reducing the lump sum retirement benefits of employees who worked beyond their first year of eligibility (age 55 for teachers and administrators and age 60 for support staff). EEOC prevailed on summary judgment and the relief issues were resolved through a consent decree providing $458,354 in backpay to 50 individuals.

EEOC v. Frontier Central School District, No. 00 CV 00165 (W.D.N.Y. April 20, 2001). In this case, the EEOC alleged that the defendant instituted and administered retirement incentive plans that reduced benefits to participants retiring at older ages. The case was resolved through a consent decree providing $200,000 in monetary relief to 18 individuals. Defendant discontinued its retirement program and adopted a Special Resignation Incentive Agreement for Teachers which complied with the ADEA.

EEOC v. Averill Park Central School District, No. 1:00-CV-1472 DNH/RWS (N.D.N.Y. December 3, 2001). In this ADEA action, the Commission alleged that the defendant established a retirement incentive plan for instructional and noninstructional employees that reduced incentive benefits based on age. Employees retiring at age 55, the minimum age of eligibility, received 100% of the benefits, employees retiring at age 56 received 35%, employees retiring at age 57 15%, and employees retiring at age 58 or older no incentive benefits. The case was resolved through a consent decree providing $106,517 in monetary relief to nine individuals.

EEOC v. Coatesville Area School District and Coatesville Area Teacher's Ass'n, No. 00-CV-4931 (E.D. Pa. February 12, 2002). The Commission alleged that defendants, a school district and a teachers' union, maintained an early retirement incentive plan that reduced cash payments for individuals ages 53 to 60 (with incentives declining as age of retirement increased) and offered no cash payments to individuals age 61 and older, and that the school district maintained three other early retirement incentive plans that reduced or eliminated payments based on age. The case was resolved through a consent decree providing $476,672 in backpay and interest to 71 teachers and 4 other school district employees. The decree also enjoins the school district from reducing, limiting, or eliminating cash-based benefits under early retirement incentive plans on the basis of age in violation of the ADEA and from retaliation.

EEOC v. Orleans Central Advisory Board of School Directors No. 2:00-CV-352 (D.Vt. April 15, 2002). The EEOC alleged that defendant school districts discriminated against older teachers by treating them differently depending upon the age at which they chose to retire. The early retirement incentive plan (ERIP) at issue expressly linked increasing age with decreasing benefits: employees retiring at age 55 or older were eligible for 7 years of health care or health care until they reached age 62, whichever came first, or could receive $5,000 annually for 3 years or until reaching 62. In granting partial summary judgment to the Commission, the court found

the provision facially discriminatory because defendants' retirement program reduced retirement benefits as a person grew older and because age was the only factor that diminished benefits. The court held that the two individuals for whom EEOC sought relief were entitled to the same benefits that a person age 55 would have obtained under the ERIP, and awarded one of them $10,000 and the other $5,000, plus prejudgment interest. The court also entered an injunction prohibiting defendants from entering into any ERIPs that violate the ADEA and ordered other injunctive relief.

4. Hiring

EEOC v. ITT Federal Service Corp., No. 99-2097 (HL) (D. P.R. January 19, 2001). The Commission alleged that defendant, which had replaced Lockheed Martin as a contractor performing services for the U.S. Navy at a base in Ceiba, Puerto Rico, refused to hire charging party, a former Lockheed employee, as an electronic technician because of his age, 48. The case was resolved through a consent decree providing charging party with $50,000 in backpay.

EEOC v. GTE South, Inc., No. 99-383 (E.D. Ky. February 9, 2001). The EEOC alleged that defendant refused to hire charging party as a line worker because of his age, 58. The case was resolved through a settlement agreement providing charging party with $48,000 in backpay and $6,000 representing a nontaxable retirement contribution, and placing charging party in a line worker position earning $19.22 an hour.

EEOC v. Texas Workforce Commission, an Agency of the State of Texas, No. 3:00-CV-0297-L (N.D. Tex. June 12, 2001). In this lawsuit, the Commission alleged that defendant's policy of refusing to rehire retirees into permanent full-time positions discriminated against retired employees because of their age. The case was resolved through a consent decree in which defendant agreed to revise its hiring practices and to provide four individuals denied rehire with a total of $117,500 in monetary relief.

5. Layoff/Reduction in Force

EEOC v. Applied Industrial Technologies, Inc., No. 8:01-CV-1075-T-26EAJ (M.D. Fla. February 22, 2002). In this lawsuit, the EEOC alleged that defendant, a nationwide manufacturer and distributor of bearings, power transmission equipment, and industrial items, laid off the two charging parties, ages 47 and 57, from their sales manager and customer service representative positions because of their ages, and discharged other PAG employees in its Southeast Area because of their ages. The case was resolved through a consent decree providing $600,000 in monetary relief to be distributed among 10 claimants. The decree also enjoins defendant from adversely affecting any individual's employment or discharging or laying off an employee in the State of Florida because of the individual's age.

EEOC v. Foot Locker Specialty, Inc., No. 99 CIV 4758 AGS (S.D.N.Y. November 1, 2002). In this ADEA lawsuit, the Commission alleged that defendant, a successor to the Woolworth chain of general merchandise retail stores, engaged in a pattern or practice of discrimination against full-time age 40 or over Woolworth store employees by systematically selecting older employees for termination and replacing them with younger part-time workers. As part of a cost-reducing nationwide corporate reorganization in 1995-97, Woolworth terminated over 600 employees who were age 40 or older and replaced them with less expensive part-time younger employees, relying on birth dates and ages in making layoff decisions. (The Woolworth retail stores ceased operations in 1997.) The case was resolved through a consent decree which provides for a total payment of $3.5 million in back pay and liquidated damages to 678 identified claimants, in amounts ranging from $1,500 to $10,000.

6. Discharge

EEOC v. Board of Regents of the University of Wisconsin System, No. 000C-564-C (June 28, 2001). The EEOC alleged that the University of Wisconsin Press, a book publishing division of the graduate school of the University of Wisconsin at Madison, discharged four employees because of their ages, 46, 47, 50, and 54. In May, following a 2-day on trial on liability the jury returned a verdict for EEOC, with a finding of willfulness, for all four individuals, and following an additional day of trial on relief, the four individuals were awarded a total of $248,538 in back and front pay and $181,889 in liquidated damages. The court subsequently ordered that defendant conduct training on age discrimination.

EEOC v. Missouri Highway and Transportation Commission, No. 4:96-CV-1042-SNL (E.D. Mo. May 30, 2001). In this ADEA action, EEOC alleged that defendant, a state agency, discriminated against charging party, age 58, in her terms and conditions of employment and discharged her because of her age and because of her complaints about age discrimination. Charging party had previously filed suit on the same ADEA claims, similar sex discrimination and retaliation claims under Title VII, and a section 1983 claim against her supervisor for violating her first amendment rights. The court dismissed charging party's private ADEA claims, holding that defendant was immune from suit under the eleventh amendment. (Subsequent to that decision but prior to EEOC filing suit, the Supreme Court decided in Kimel v. Florida Board of Regents that state entities do have eleventh amendment immunity from private ADEA actions.) EEOC's suit was consolidated with charging party's suit and the consolidated action was resolved through a consent decree providing charging party with $50,000 in backpay, $61,000 in compensatory damages, and $74,000 in attorney's fees.

EEOC v. BellSouth Telecommunications, Inc., No. 1:01-CV-0803-RWS (N.D. Ga. January 22, 2002). The Commission alleged that defendant discharged charging party from her systems application manager position because of her age, 50. The case was resolved through a consent decree providing charging party with $200,000 in backpay and with pension credits based on her being employed from her discharge in January 1999 until January 22, 2002, with earnings of $200,000 during that period.

EEOC v. Kraft Foods North America, Inc., No. CV 01-1694 RHK/JMM (D. Minn. April 22, 2002). In this lawsuit, the Commission alleged that defendant, as a successor to Nabisco, Inc., discharged charging party from his account manager position during a reorganization of Nabisco's Vend Sales Division, because of his age, 48. The case was resolved through a consent decree providing charging party, who had filed a companion suit under the Minnesota Human Rights Act, with $270,000 in monetary relief.

EEOC v. Anderson & Vreeland, Inc., No. C-01-02716 PJH (N.D. Cal. November 1, 2002). The Commission alleged that defendant, a national supplier of printing equipment and materials based in Ohio, discriminated against four former long term employees who were over the age of 40 when it terminated them and replaced them with substantially younger individuals. The four claimants (a regional sales manager, a draftsman, and two sales representatives) were between the ages of 60 and 69 at the time of their discharge and had worked for defendant for periods ranging from 11 to 18 years. The case was resolved through a consent decree which provides for a total payment of $554,000 to the four claimants and enjoins defendant from discriminating on the basis of age and from retaliation.

7. Promotion

EEOC v. City of Griffin, No. 3-99-cv-158-JTC (N.D. Ga. March 21, 2001). The Commission alleged that defendant denied charging party a promotion from a part-time lineman to a full-time senior lineman position because of his age, 66. The case was resolved through a consent decree providing charging party with $125,000 in monetary relief.

EEOC v. Mercedes-Benz USA, Inc., No. 00-33 (D. N.J. December 7, 2001). The EEOC alleged that defendant failed to promote charging party to the position of National Customer Assistant Representative because of his age, 72. The case was resolved through a consent decree providing charging party with $70,000 in monetary relief.

8. Retaliation

EEOC v. Wal-Mart Stores, Inc., No. 99 C 7261 (N.D. Ill. July 10, 2001). The EEOC alleged that defendant demoted charging party from her customer service manager position to a night shift floor associate position because she complained that she was denied a promotion to chief customer service manager because of her age (47) and that defendant then discharged charging party because she filed an age discrimination and retaliation charge with EEOC. The case was resolved through a consent decree providing charging party with $15,000 in backpay, $14,000 in nonpecuniary compensatory damages, and $26,000 for miscellaneous reimbursements such as lost profit sharing and medical expenses.

9. Disparate Impact

EEOC v. Board of Trustees of the University of Louisiana System, No. 3:98CV0010 (W.D. La. July 18, 2001). The EEOC alleged that defendant's policy of prohibiting full-time employment of individuals who have retired from service in the state retirement system has a disparate impact on individuals 40 years of age and older. The court granted summary judgment to defendant. The court first held that disparate impact was not a viable theory of liability under the ADEA, relying on recent decisions in the Fifth and Eleventh Circuits, on language in the Supreme Court's decision in Hazen Paper Co. v. Biggins, 507 U.S. 604 (1993), that the use of factors correlated with age, such as pension status, was acceptable in making employment decisions, and on Congress having amended Title VII in 1991 to include a cause of action for disparate impact while failing to amend the ADEA in the same way. The court then held that even if disparate impact liability existed under the ADEA, EEOC had failed to establish such a claim. The court said that while it was true that only persons in the protected age group were affected by defendant's policy, they were affected because of their status as state retirees, not because of their age. The court said case law required EEOC to make some comparison to establish a causal connection between the policy and a class based imbalance in the workforce, and that EEOC had failed to show what overall effect the policy has on protected age group workers within the Board system and thus had not shown any imbalance in the workforce.

10. Proof Issues

Ratliff v. City of Gainesville, 228 F.3d 1105 (5th Cir. July 17, 2001). The Fifth Circuit reversed the judgment in this private ADEA action challenging the City of Gainesville's decision not to hire the plaintiff as city manager. The court, agreeing with the arguments advanced by the EEOC as *amicus curiae*, held that the district court committed prejudicial error by failing to instruct the jury that it may presume that the employer was motivated by age discrimination if it finds that the employer's stated reason for not hiring the plaintiff is false.

11. Attorney's Fees

EEOC v. Complete Dewatering, Inc., 281 F.3d 1283 (Table) (11th Cir. December 11, 2001). The Eleventh Circuit reversed the district court's grant of attorney's fees to the defendant in a unanimous, *per curiam* decision. Applying the "substantially justified" standard of the Equal Access to Justice Act (EAJA), the lower court had awarded $215,000 in fees. On appeal, the Commission argued that the EAJA does not apply to its enforcement actions and, alternatively, that its position was substantially justified within the meaning of EAJA. The Eleventh Circuit agreed that the EEOC's position was justified in that it had "enough indication of direct evidence of discrimination" to have "substantial justification to pursue the case." Acknowledging that a prior panel of the Eleventh Circuit had discounted the same evidence in affirming summary

judgment, the court nonetheless found that a ruling against a party on summary judgment does not preclude a finding that a case was substantially justified. The court did not reach the Commission's broader argument, that EAJA does not apply to actions brought by the Commission under the ADEA.

ITEM 16—ENVIRONMENTAL PROTECTION AGENCY

EPA'S AGING INITIATIVE

The population of people 65 years or older is at risk of developing chronic diseases and disabling conditions which may be caused or exacerbated by environmental pollution. Currently there are about 35 million people 65 years or older in the United States, and over the next 30 years that number is expected to double. Research is needed to determine whether there are special susceptibilities associated with older adults compared to healthy younger adults to meet legislative mandates concerning protection of susceptible subpopulations, and preventive measures are necessary to ensure that older Americans remain as healthy as possible.

Due to the normal aging process, older Americans may have increased health risks from exposures to environmental pollutants. Different exposures patterns, age-related changes in metabolic processes, lifetime accumulations of persistent toxicants, and reduced reserve capacity in different organ systems are some of the critical characteristics that may make older adults a sub-population with special susceptibilities to toxicant-induced dysfunction or degeneration. We have learned that particular matter (PM), fine particles from particle pollution which is a mixture of microscopic solids and liquid droplets found in the air, can exacerbate existing heart and lung diseases among older Americans and is responsible for increased hospitalizations. PM has been linked to a range of serious respiratory and cardiovascular (heart and blood vessel) problems. It has been estimated that exposures to PM may result in tens of thousands of premature deaths per year and many more cases of illness. In addition, we know that Chronic Obstructive Pulmonary Disease (COPD) is one of the most common health conditions among older persons and can be exacerbated by environmental triggers such as second-hand smoke, Code Red and Orange air quality days, and other indoor air contaminants. The annual cost for treatment of COPD is $32 billion annually with 75 percent directed to treatment of acute exacerbations.

In October 2002, EPA launched a new Aging Initiative representing the Agency's first coordinated effort to address the environmental health issues of older persons. A key objective of the Aging Initiative is the development of a National Agenda for the Environment and the Aging to be released early in 2004. The National Agenda will: 1) identify research gaps in environmental health as it relates to older persons and practical interventions to prevent exposures to hazards; 2) examine the impact that a rapidly growing aging population will have on the environment, and 3) encourage volunteerism among older persons in their communities to reduce environmental health hazards. The National Agenda will

lay out a strategy that combines research and educational programs that promote preventive actions.

The framework for the National Agenda draws upon ongoing efforts throughout the EPA, including an inventory of approximately 75 aging-related research, outreach and intervention projects. Air quality issues and their impact on respiratory, cardiovascular and pulmonary health were the focus of most of the projects in the inventory. For example, the Baltimore, Maryland PM studies linked exposure to fine particulate matter to the health of older persons in a retirement community, and several projects have highlighted EPA's collaboration with aging and intergenerational organizations across the nation. There are projects in Utah as well as New York and Connecticut where volunteers with the Retired Senior Volunteer Program (RSVP) are involved in a variety of Superfund cleanup activities; another project in Illinois conducted by retired older volunteers to help identify contaminants in drinking water supplies; and a project with the Wyoming Energy Council that addressed health effects on older persons caused by exposure to radon, a know carcinogen, and potentially hazardous solid waste.

Throughout the spring of 2003, EPA invited public comments and convened a series of six listening sessions across the United States (FL, TX, IA, PA, CA, and MD) to receive public input for the National Agenda. EPA's continuing efforts, the public comments, and the proceedings from a December 2002 National Academy of Sciences Workshop on the differential susceptibility of older persons to environmental hazards will form the basis for the recommendations that will be included in the National Agenda for the Environment and the Aging that will help to chart a future that is environmentally healthy for older Americans.

For more information on EPA's efforts to protect the health of older Americans, please visit www.epa.gov/aging.

THE OFFICE OF HUMAN RESOURCES AND ORGANIZATIONAL SERVICES (OHROS)

In honor of Older Americans Month observed in May 2001, the OHROS Senior Environmental Employment (SEE) Office sponsored participation in the District of Columbia's Office on Aging's 37th Annual Senior Citizens' Day which celebrated the theme of "The Many Faces of Aging." The AARP 5-Alive Mature Driving Program, which is the first and most recognized nationwide course created especially for older drivers, was also offered.

The SEE Program Manager presented a workshop on EPA's SEE Program at the 2002 Joint National Conference of the American Society of Aging/National Council of Aging. The workshop demonstrated how the SEE Program utilizes the wealth of talent, experience and skills possessed by retired and unemployed older Americans. The workshop also explained how bringing workers age 55 and above into the workforce enriches the lives of the individuals in the program, infuses knowledge and experiences gained from prior work histories into the workforce, and supports government staff in administering programs. The work being done by the many SEE participants demonstrates the effectiveness of older Americans in helping to protect our environment.

SENIOR ENVIRONMENTAL EMPLOYMENT (SEE) PROGRAM

The Environmental Programs Assistance Act of 1984 (Public Law 98–313) authorizes the Environmental Protection Agency (EPA) to enter into grants or cooperative agreements with private non-profit organizations, as designated by the Secretary of Labor under Title V of the Older American Act. These cooperative agreements, administered by the EPA under the Senior Environmental Employment (SEE) Program, are in support of environmental programs, objectives, and initiatives utilizing the wealth of talent, experience, and skills possessed by retired and unemployed older Americans age 55 and over.

There are six national aging organizations with whom cooperative agreements were funded by EPA with during calendar years 2001 and 2002: The National Association for Hispanic Elderly, National Asian Pacific Center on Aging, National Caucus and Center on Black Aged, Inc., National Council on the Aging, Inc., National Older Worker Career Center, Inc., and Senior Service American, Inc. Under the auspices of cooperative agreements, these organizations are responsible for recruiting qualified candidates for enrollment in positions that support federal, state and local environmental offices.

SEE enrollees provide a wide array of technical assistance. These older workers are involved in every aspect of EPA's effort to improve our environment, from providing clerical support to performing radiation and air pollution monitoring. The SEE Program provides support to EPA where it is most needed, and enables older workers to remain active using their knowledge, skills, and life experiences to perform meaningful tasks that promote and support important agency environmental programs and initiatives.

ITEM 17—FEDERAL COMMUNICATIONS COMMISSION

REPORT ON ACTIVITIES AFFECTING OLDER AMERICANS DURING CALENDAR YEARS 2001 AND 2002

The following is a summary of Federal Communications Commission activities during 2001 and 2002 that affected older Americans. The activities are grouped by the Commission organizational units that had primary responsibility for them. While few Commission activities target older Americans specifically, some have had a significant impact on older Americans since they address matters that are of particular concern to them. As an example, the Commission has been working to increase access to telecommunications services for people with hearing or visual disabilities. Since it is likely that many Americans with these disabilities are elderly, the Commission believes that its actions in this area are providing a direct, tangible benefit to the elderly.

Wireless Telecommunications Bureau

Emergency Access: Digital Wireless-TTY Compatibility.—During 2001 and 2002, the Commission oversaw the successful implementation in digital wireless networks of the capability to transmit 911 calls from text telephone (TTY) devices. Previously, these calls could not be transmitted over digital wireless systems because the Baudot-encoded audio tones produced by TTY devices were unable to be passed through digital systems. Digital wireless service providers were required to begin transmitting TTY 911 calls by June 30, 2002, in accordance with the Commission's Order. The Order also imposed reporting requirements to enable the Commission to monitor the implementation. The majority of digital wireless service providers satisfied the implementation requirements in a timely manner; some small, rural service providers sought extensions or waivers due to their unique circumstances.

Hearing Aid Compatibility with Digital Wireless Phones.—In order to preserve access to wireless telecommunications by individuals with hearing disabilities, the Commission reviewed its rules governing hearing aid compatibility with wireless phones during 2001 and 2002. The Hearing Aid Compatibility Act of 1988 requires most phones manufactured or imported for use in the United States to be hearing aid compatible. However, the statute exempted wireless phones from this requirement, and Section 68.4 of the Commission's rules implemented the exemption. In fulfillment of the statute's mandate that the Commission periodically review the exemption and in response to a consumer group's petition, the Commission initiated a proceeding to examine the issue.

Although analog wireless phones do not usually cause interference with hearing aids or cochlear implants, digital wireless

phones sometimes do because of electromagnetic energy emitted by the phone's antenna, backlight, or other components. Because digital wireless phones are technically superior and offer cheaper calling plans, they are vastly more popular than their analog counterparts. Access to them is essential to the safety and increased convenience that consumers demand. Based on the decline in analog service offerings coupled with the rise in more efficient, lower-cost, and feature-rich digital offerings, the Commission tentatively concluded that limiting the hearing aid compatibility exemption for wireless phones would serve the public interest. The Commission also tentatively concluded that continuation of the exemption without limitation would have an adverse effect on individuals with hearing disabilities.

Wireline Competition Bureau

Universal Service.—The Telecommunications Act of 1996 established certain principles for the Commission to follow in revising and expanding the scope and definition of "universal service" in telecommunications services for all Americans. Of particular note to older Americans, these principles include ensuring that all consumers, including low-income consumers, have access to affordable telecommunications services and ensuring that health care providers and libraries have access to advanced telecommunications services.

Rural Health Care Support Mechanism and Support for Libraries.—Consistent with these principles, the Commission established new universal service support mechanisms for rural health care providers and libraries. The support mechanism for rural health care providers helps to link public and non-profit health care providers located in rural areas to urban medical centers so that patients living in rural America will have access, through the telecommunications network, to the same advanced diagnostic and other medical services that are enjoyed in urban communities. Rural health care support enables rural health care providers to obtain telecommunications services at rates available in urban areas and Internet access without toll charges. The support mechanism for schools and libraries implements Congress's mandate to ensure that the nation's schools and libraries receive access to the vast array of resources that are available through the telecommunications network. The schools and libraries program enables eligible schools and libraries to obtain discounts ranging from 20 to 90 percent for eligible telecommunications services, Internet access, and internal connections. The discounts are based on economic need and whether the applicant is located in an urban or rural area.

During 2001–2002, the Commission continued to implement these programs. In April 2002, the Commission released a Notice of Proposed Rulemaking seeking comment on ways of expanding the eligibility criteria for participation in the rural health care program. The proposed changes are intended to enable more Americans located in rural areas to have access to the most up-to-date medical advice and treatment. In January 2002, the Commission also released a Notice of Proposed Rulemaking initiating a focused review of Commission rules governing the schools and libraries universal service mechanism.

"Lifeline and Link-Up" Programs.—During 2001–2002, the Commission also continued to refine and expand its "Lifeline" and "Link-Up" programs, which help low-income consumers purchase affordable telecommunications services. The federal Lifeline programs provide up to $10.00 per month to reduce eligible low-income consumers' monthly telephone bills. Additional Lifeline support of up to $25 per month is available to eligible low-income consumers located on tribal lands. The Link-Up program helps low-income consumers pay the initial costs of commencing telephone service. Low-income consumers receive discounts up to $30 on initial connection charges. Enhanced Link-Up support provides an additional discount of up to $70 on initial connection charges for low-income consumers living on tribal lands.

Broadband.—In 2002 the Commission issued a Notice of Proposed Rulemaking aimed at furthering broadband access to the Internet for all Americans. For a number of reasons, development of the Internet is of particular benefit to older Americans. Through the use of Internet e-mail, for example, older Americans can stay in touch with family and friends in distant locations. Through access to on-line news media outlets, they can keep up with local, national, and international news. Older Americans who wish to keep their minds active and engaged can take advantage of informational websites and on-line distance learning through colleges and universities. Finally, the Internet gives older Americans—and their doctors—in rural areas access to medical care and information from larger, more sophisticated medical facilities in distant locations.

Media Bureau

Video Accessibility.—Older Americans with hearing and visual disabilities can be helped by a number of technologies related to television, including closed captioning and "video description." Video description is the description of key visual elements in programming, inserted into natural pauses in the audio portion of programming designed to make television programming more accessible to the many Americans who have visual disabilities. In April 2002 Commission rules went into effect mandating that a certain amount of programming contain video description, but in November 2002 the United States Court of Appeals for the District of Columbia Circuit vacated those rules. The pending 2003 FCC Reauthorization Bill (reported by the Senate Commerce Committee) reinstates the Commission's rules implementing video description.

Closed Captioning.—The Telecommunications Act of 1996 directed the Commission to prescribe rules and implementation schedules for the closed captioning of video programming regardless of the entity that provides the programming to consumers or the category of programming. The Commission has established rules requiring that both analog technology and digital technology television programming contain closed captioning. In 2002, as part of the Commission's periodic review of the progress of the transition of the nation's television broadcast system from analog to digital, the Commission initiated an assessment whether additional actions are required to ensure the accessibility and functioning of closed captioning service for digital television.

Emergency Information.—The Commission adopted rules in 2000 requiring broadcasters or multichannel video program distributors ("MVPDs") that provide local emergency information to make that information accessible to persons with hearing and visual disabilities. Emergency information is defined as that information intended to protect life, health, safety, and property, i.e., "critical details" about an emergency and how to respond to the emergency. Critical details include, among other things, specific details regarding the areas that will be affected by the emergency, evacuation orders, detailed descriptions of areas to be evacuated, specific evacuation routes, approved shelters or the way to take shelter in one's home, instructions on how to secure personal property, road closures, and how to obtain relief assistance. Under the Commission's rules, broadcast stations and MVPDs that provide local emergency information must make that information accessible to people with hearing disabilities through closed captioning or other method of visual presentation. Broadcast stations and MVPDs that provide local emergency information during regularly scheduled newscasts, unscheduled newscasts that preempt regularly scheduled programming, or during continuing coverage of a situation, must make that information accessible to people with visual disabilities through oral description of the information. Broadcast stations and MVPDs that provide local emergency information in other programs, such as through a crawl or a scroll, must sound a tone when they provide that information in order to alert persons with visual disabilities to turn to other media, such as a radio, to get the emergency information.

During 2001 and 2002 the Commission continued to handle correspondence from the public regarding the obligations of broadcasters and MVPDs to provide emergency information to visually impaired viewers. In addition, in 2001 the Commission granted a waiver through 2004 to MVPDs that receive their emergency information from The Weather Channel ("TWC") via Star III and Weather Star Jrs. of the requirement that they provide an aural tone before each crawl or scroll of emergency information. TWC sought the waiver based on its plans to upgrade and replace its computers in 2003/2004 which supply the aural tone. Without this waiver, the cost of complying with the Commission's rules in a timely fashion would have cost TWC approximately $34 million.

Senior Citizen Discounts for Cable Service.—Senior citizen discounts benefit older Americans who may have limited incomes. By enacting Section 623(e)(1) as part of the system of rate regulation pursuant to the 1992 Cable Act, Congress intended to encourage cable operators to offer, and to continue to offer through existing franchise agreements, reasonable discounts to senior citizens or other economically disadvantaged groups. In 2001 and 2002 the Bureau handled complaints on an ongoing basis regarding the provision of senior citizen discounts and provided assistance to cable customers who contacted the Commission on this issue.

International Bureau

Mobile Satellite Service 911.—In 2002, the Commission continued its efforts to promote public safety by examining whether the rules that require wireless carriers to bring emergency assistance to

wireless callers throughout the United States should be extended to certain non-traditional services. Among these services, the Commission proposed to require mobile satellite service (MSS) providers to establish call centers for the purpose of answering customers' 911 emergency calls. In addition, the Commission sought information regarding MSS enhanced 911 implementation (provision of caller phone number and location) and timelines for achievability. 911 services, including those deliverable by satellite, are particularly important to older Americans.

Consumer & Governmental Affairs Bureau

Hearing Aid Compatibility.—In 2002 the Commission crafted an outreach plan to be implemented in 2003 in conjunction with the Hearing Aid Compatibility initiative. The outreach constituted contacting manufacturers and audiologists to work to bring the new policies and information to their customers and clients.

Consumer Advisory Committee.—In November 2002 the Commission renewed the charter of the Consumer Advisory Committee (CAC), originally established in 2000 as the Consumer/Disability Telecommunications Advisory Committee. The Committee is comprised of representatives from industry and consumer groups, including consumers with disabilities and a representative from the AARP. The mission of the Consumer Advisory Committee is to make recommendations to the Commission regarding consumer issues within the jurisdiction of the Commission and to facilitate the participation of consumers (including people with disabilities and underserved populations, such as Native Americans and persons living in rural areas) in proceedings before the Commission.

Telecommunications Relay Service (TRS).—Title IV of the Americans with Disabilities Act (ADA), which is codified at Section 225 of the Communications Act, mandates that the Commission ensure that interstate and intrastate TRS are available, to the extent possible and in the most efficient manner, to individuals in the United States with hearing and speech disabilities. Title IV aims to further Congress' goal of universal service by providing, to individuals with hearing or speech disabilities, telephone services that are functionally equivalent to those available to individuals without such disabilities. Since the establishment of this mandate, the Commission has taken numerous steps to increase the availability of TRS, and to ensure that TRS users have access to the same services available to all telephone service users. Throughout 2001 and 2002, the Commission also issued orders to streamline and refine the ability for more Americans with disabilities to access telecommunications.

Conferences and Forums.—The Consumer and Governmental Affairs Bureau participates annually in the AARP conference and local functions in the Washington, D.C., area. In February 2001 the Commission observed National Consumer Protection Week by focusing on the concerns of senior citizens and organizing three events to discuss telecommunications issues of particular interest to them. These issues included implementation of the Telephone Consumer Protection Act, procedures for filing a complaint, slamming and telemarketing rules, video description, and closed captioning.

ITEM 18_GENERAL ACCOUNTING OFFICE

G A O
Accountability • Integrity • Reliability

United States General Accounting Office
Washington, DC 20548

November 21, 2003

The Honorable Larry E. Craig
Chairman
Special Committee on Aging
United States Senate

Subject: *Aging Issues: Related GAO Products in Calendar Years 2001 and 2002*

Dear Mr. Chairman:

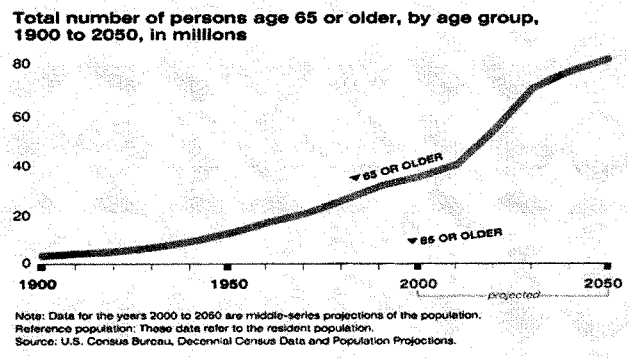
This report responds to the Committee's request for a compilation of our calendar years 2001 and 2002 products pertaining to older Americans and their families.

We are in the midst of one of the most profound changes in American history—America's population, estimated at over 288 million in 2002,[1] is growing older at a rapid pace. The number of Americans age 65 and older, estimated at 35 million in 2000, is expected to grow to 70 million by 2030 and to about 82 million in 2050, according to Bureau of the Census projections (fig. 1). Census projections also indicate that the fastest growing segment within the older population is individuals age 85 and older. This group, estimated at about 4 million in 2000, is expected to grow to 19 million by 2050.

The nation's aging population promises to have major policy and budgetary implications for the federal government. While there will be large increases in the number of older people who will be active and in very good health, there will also be growing numbers of older Americans requiring increased medical and long-term care. Health care has been one of the most rapidly rising elements of federal spending, growing at an average annual rate twice that of the rest of the federal budget over the last 10 years. Of particular concern is the growth in Medicare expenditures, estimated to total about $264 billion in 2002. Without changes, Medicare is expected to nearly double its share of the economy by 2030, crowding out other spending and economic activity of value.

[1]Population Division, U.S. Census Bureau, Table NA-EST2002-01–National Population Estimates: April 1, 2000 to July 1, 2002 (Release Date: December 31, 2002).

Figure 1: Total Number of Persons Age 65 or Older, by Age Group, 1900 to 2050 (in millions)



In addition, Social Security has long served as the foundation of the nation's retirement income system. About 39 million people receive Social Security retirement and survivor benefits. For one-fifth of the elderly, Social Security is the sole source of income. The declining ratio of workers to retirees will have fundamental implications for Social Security and the economy. Although Social Security payroll tax revenues currently exceed expenditures, projections suggest that beginning in 2017, spending will exceed revenues by growing proportions and that in 2041, the Social Security Trust Fund will be depleted. Addressing the needs of the elderly will likely become increasingly challenging and require sufficient knowledge about the issues facing this population.

One of our goals is to provide continued support of congressional and federal efforts relating to the health needs of an aging and diverse population and a secure retirement for older Americans. In striving to meet this goal, our work on aging-related programs and issues continues to reflect the broad range and importance of federal programs for older Americans. Our work during calendar years 2001 and 2002 primarily covered issues concerning health, income security, and veterans. In the compilation of work you requested, we describe two types of products that relate to older Americans:

- reports and correspondences (66 in total), and
- congressional testimonies (36 in total).

The product summaries included were prepared shortly after the products were issued and, therefore, reflect the results of our work at that time. The issues addressed by these products are presented in table 1 and the summaries themselves are in enclosure I.

Table 1: GAO Products Relating to the Elderly in Calendar Years 2001 and 2002

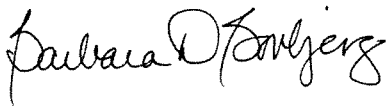
Elderly issues	Reports and	Testimonies

	correspondence	
Health issues	35	21
Income security issues	15	4
Veterans/DOD issues	13	9
Other issues	3	2
Total	**66**	**36**

Source: GAO.

If you or your staff have any questions about the information in this report, please contact me at (202) 512-7215 or bovbjergb@gao.gov. Other key contributors to this report were Shelia D. Drake and Gwendolyn M. Adelekun.

Sincerely yours,



Barbara D. Bovbjerg
Director, Education, Workforce, and
Income Security Issues

CALENDAR YEARS 2001 AND 2002, ISSUES AFFECTING OLDER AMERICANS

During calendar years 2001 and 2002, GAO issued 102 reports on issues affecting older Americans. Of these, 56 were on health issues, 19 were on income security issues, 22 were on veterans' issues, and 5 were other issues related to older Americans.

Reports and Correspondence: Calendar Years 2001 and 2002, Issues Affecting Older Americans

HEALTH ISSUES

Federal Employees' Health Plans: Premium Growth and OPM's Role in Negotiating Benefits (GAO-03-236, 31-DEC-02)

Federal employees' health insurance premiums have increased at double-digit rates for 3 consecutive years. GAO was asked to examine how the Federal Employees Health Benefits Program's (FEHBP) premium trends compared to those of other large purchasers of employer-sponsored health insurance, factors contributing to FEHBP's premium growth, and steps the Office of Personnel Management (OPM) takes to help contain premium increases compared to those of other large purchasers. GAO compared FEHBP to the California Public Employees' Retirement System (CalPERS), General Motors, and a large private employer purchasing coalition in California as well as data from employee benefit surveys.

FEHBP's premium trends from 1991 to 2002 were generally in line with other large purchasers--increasing on average about 6 percent annually. OPM announced that average FEHBP premiums would increase about 11 percent in 2003, 2 percentage points less than in 2002 and less than some other large purchasers are expecting. FEHBP enrollees would likely have paid even higher premiums in recent years if not for modest benefit reductions and enrollees who shifted to less expensive plans. Increasing premiums are related to the plans' higher claims expenditures. For FEHBP's three largest plans, about 70 percent of increased claims expenditures from 1998 to 2000 was due to prescription drugs and hospital outpatient care. Most of the increase in drug expenditures was due to higher plan payments per drug, while the increase in hospital outpatient care expenditures was due to higher utilization. OPM relies on enrollee choice, competition among plans, and annual negotiations with participating plans to moderate premium increases. Whereas some large purchasers require plans to offer standardized benefit packages and reject bids from plans not offering satisfactory premiums, OPM contracts with all plans willing to meet minimum standards and allows plans to vary benefits, maximizing enrollees' choices. Each year, OPM suggests cost containment strategies for plans to consider and relies on participating plans to propose benefits and premiums that will be competitive with other participating plans. OPM generally concurred with our findings.

Fruits and Vegetables: Enhanced Federal Efforts to Increase Consumption Could Yield Health Benefits for Americans (GAO-02-657, 25-JUL-02)

Fruits and vegetables are a critical source of nutrients and other substances that help protect against chronic diseases. Yet fewer than one in four Americans consumes the 5 to 9 daily servings of fruits and vegetables recommended by the federal Dietary Guidelines for Americans. Fruit and vegetable consumption by the general public as a whole has increased by about half a serving under key federal nutritional policy, guidance, and educational programs, as shown by the national consumption data compiled by federal agencies. But key federal food assistance programs have had mixed effects on fruit and vegetables consumption, as shown by national consumption data. However, increasing fruit and vegetable consumption is not a primary focus of these programs, which are intended to reduce hunger and support agriculture. A number of actions the federal government could take to encourage more Americans to consume the recommended daily servings have been identified. These include expanding nutrition education efforts, such as the 5 A Day Program; modifying the special supplemental Nutrition Program for Women, Infants, and Children to allow participants to choose from more of those fruits and vegetables; expanding the use of the Department of Defense Fresh Fruit and Vegetable Project in schools; and expanding farmers' market programs for food assistance participants and the elderly. These options could require additional resources or redirecting resources from other programs.

Health Care: Adequacy of Pharmacy, Laboratory, and Radiology Workforce Supply Difficult to Determine (GAO-02-137R, 10-OCT-01)

Concerns have been growing about the supply of health care workers and the future needs of an aging population. Shortages of nurses and nurse aides, the two largest categories of health care workers, are of particular concern. Although the number of pharmacists has grown during the past decade, the increasing demand for pharmacy services is outpacing the growth in supply, according to the Department of Health and Human Services. Provider and professional associations have reported high vacancy rates and a decline in new entrants to the laboratory and radiologic fields. However, employment and earnings data for laboratory and radiologic technologists and technicians do not indicate a clear picture about the current balance of supply and demand for these workers. Demographic changes, technological advances, and management decisions on how staff and technology are used will affect the future demand for health care workers.

Health Products for Seniors: 'Anti-Aging' Products Pose Potential for Physical and Economic Harm (GAO-01-1129, 07-SEP-01)

Evidence from the medical literature shows that a variety of frequently used dietary supplements marketed as anti-aging therapies can have serious health consequences for senior citizens. Some seniors have underlying diseases or health conditions that make the use of the product medically inadvisable, and some supplements can interact with medications that are being taken concurrently. Furthermore, studies have found that products sometimes contain harmful contaminants or much more of an active ingredient than is indicated on the label. Unproven anti-aging and alternative medicine products also pose an economic risk to seniors. The Food and Drug Administration (FDA) and the Federal Trade Commission (FTC) have identified several products that make advertising or labeling claims with insufficient substantiation, some costing consumers hundreds or thousands of dollars apiece. Federal and

state agencies have efforts under way to protect consumers of these products. FDA and FTC sponsor programs and provide educational materials for senior citizens to help them avoid health fraud. At the state level, agencies are working to protect consumers of health products by enforcing state consumer protection and public health laws, although anti-aging and alternative products are receiving limited attention. GAO summarized this report in testimony before Congress (GAO-01-1139T).

Long-Term Care: Availability of Medicaid Home and Community Services for Elderly Individuals Varies Considerably (GAO-02-1121, 26-SEP-02)

As the baby boomers age, spending on long-term care for the elderly could nearly quadruple by 2050. Medicaid, the joint federal state health financing program for low income individuals is currently the largest payer for long-term care services and is anticipated to face substantial increases in spending as demand for long-term care increases. Nursing home care traditionally has accounted for most Medicaid long-term care expenditures, but the high costs of such care and the preference of many individuals to stay in their own homes has led states to expand their Medicaid programs to provide coverage for home- and community-based long-term care. The case managers GAO contacted in four states for two hypothetical elderly individuals generally offered care plans that relied on in-home services rather than other residential care settings. However, the in-home services offered varied considerably. The care that case managers offered the two hypothetical individuals sometimes differed due to state policies or practices that shaped the availability of their Medicaid covered services. In two of the four states there was a waiting list for home and community based services and some states had caps or other practices that limited the amount of Medicaid in-home care that could be offered.

Mammography: Capacity Generally Exists to Deliver Services (GAO-02-532, 19-APR-02)

Breast cancer is the second leading cause of cancer deaths among American women. In 2001, 192,200 new cases of breast cancer were diagnosed and 40,200 women died from the disease. The probability of survival increases significantly, however, when breast cancer is discovered in its early stages. Currently, the most effective technique for early detection of breast cancer is screening mammography, an X-ray procedure that can detect small tumors and breast abnormalities up to two years before they can be detected by touch. Nationwide data indicate that mammography services are generally adequate to meet the growing demand. Between 1998 and 2000, both the population of women 40 and older and the extent to which they were screened increased by 15 percent. Although mammography services are generally available, women in some locations have problems obtaining timely mammography services in some metropolitan areas. However, the greatest losses in capacity have come in rural counties. In all, 121 counties, most of them rural, have experienced a drop of more than 25 percent in the number of mammography machines in the last three years. Officials from 37 of these counties reported that the decrease had not had a measurable adverse effect on the availability of mammography services. By contrast, in 18 metropolitan counties that lost a smaller percentage of their total capacity, officials in half of the counties reported service disruptions. Officials from six other urban areas, including Houston and Los

Angeles, reported that public health facilities serving low-income women had long waiting times. However, most women whose clinical exam or initial mammogram indicated a need for a follow-up mammogram were able to get appointments within one to three weeks.

Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns (GAO-02-817, 12-JUL-02)

States provide health care coverage to about 40 million uninsured, low-income adults and children under two federal-state programs--Medicaid and the State Children's Health Insurance Program (SCHIP). To receive federal funding, states must meet statutory requirements, including providing certain levels of benefits to specified populations. Under section 1115 of the Social Security Act, the Secretary of Health and Human Services (HHS) can waive many of the statutory requirements in the case of experimental, pilot, or demonstration projects likely to promote program objectives. From August 2001 through May 2002, HHS approved four waiver proposals from states to either expand health insurance to uninsured populations or extend pharmacy coverage to low-income seniors, consistent with the new goals. Of the nine proposals that were under review as of June 2002, five sought to expand coverage to uninsured populations, while four sought to provide pharmacy benefits for low-income seniors. GAO has both legal and policy concerns about the extent to which the approved waivers are consistent with the goals and fiscal integrity of Medicaid and SCHIP. The legal concern is that HHS has allowed Arizona to use unspent SCHIP funding to cover adults without children, despite SCHIP's objective of expanding health coverage to low-income children. GAO found that HHS' approval of the waiver to cover childless adults is not consistent with this objective, and it is not authorized. A related policy concern is that HHS used its waiver authority to allow Arizona and California to use SCHIP funds to cover parents of SCHIP and Medicare-eligible children with no regard to cost effectiveness when the statute provides that family coverage may be provided only if it is cost-effective to do so--that is, with no additional costs beyond covering the child. An opportunity for the public to learn about and comment on pending waivers has not been consistently provided in accordance with policy adopted by HHS in 1994. At the federal level, since 1998 HHS has not followed established procedures to publish notification of new and pending section 1115 waiver applications in the Federal Register with a 30-day comment period.

Medicare: Beneficiary Use of Clinical Preventive Services (GAO-02-422, 10-APR-02)

Preventive medicine, including immunizations for many diseases and screening for some types of cancer, holds the promise to extend and improve the quality of life for millions of Americans. Medicare now covers three preventive services for immunizations and seven for screenings, and the Centers for Medicare and Medicaid Services (CMS) sponsors "interventions" to increase the use of preventive services. GAO found that the use of preventive services varies widely by service, state, ethnic group, income, and education. The greatest differences among ethnic groups were for immunization rates. Cancer screening rates tended to differ according to income and education level. CMS pays for interventions that promote breast cancer screenings and pneumonia and flu shots. Most of the techniques being used, such as reminder systems that medical offices can use to alert doctors and patients to needed cancer screenings, have been effective. CMS is evaluating what its current efforts have accomplished and expects the results later in the year.

Medicare: Communications with Physicians Can Be Improved (GAO-02-249, 27-FEB-02)

Unlike other federal programs that make expenditures under the direct control of the government, Medicare constitutes a promise to pay for covered medical services provided to its beneficiaries by about one million providers. Given this open-ended entitlement, it is essential that appropriate and effective rules and policies be specified so that only necessary services are provided and reimbursed. Congress and the Centers for Medicare and Medicaid Services (CMS) have promulgated an extensive body of statutes, regulations, policies, and procedures on what shall be paid for and under what circumstances. Information that carriers give to physicians is often difficult to use, out of date, inaccurate, and incomplete. Medicare bulletins that carriers use to communicate with physicians are often poorly organized and contain dense legal language. Similarly, other means of communicating with physicians, such as toll-free provider assistance lines and websites, have problems with accuracy and completeness. Although all carriers issue bulletins, operate call centers, and maintain websites, each carrier develops its own communications policies and strategies. This approach results in a duplication of effort as well as variations in the quality of carrier communications. CMS provides little technical assistance to help carriers develop effective communication strategies. Neither CMS carrier oversight nor self-monitoring by the carriers is comprehensive enough to provide sufficiently detailed information that could either pinpoint specific communication problems or identify poorly performing carriers. CMS is working to improve its physician communications by consolidating new instructions and regulations and issuing them on a more predictable schedule to lessen the burden of frequent policy changes that physicians cannot anticipate. CMS is also enhancing its education programs for both physicians and carrier staffs and expanding its efforts to obtain physician feedback. Finally, CMS is improving its national website and intends to develop a single web-based source of information for physicians.

Medicare: Orthotics Ruling Has Implications for Beneficiary Access and Federal and State Costs (GAO-02-330, 22-MAY-02)

In the late 1980s and early 1990s, the Health Care Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), became concerned that some suppliers were improperly billing Medicare for items that attach to wheelchairs and other equipment. Some suppliers were billing for such items using codes for orthodic devices, including arm, back, and neck braces that provide support for or immobilize weak or injured limbs, while others were billing using codes for durable medical equipment, which includes equipment such as wheelchairs and crutches that can withstand repeated use and is appropriate for home use. Whether an item is billed as an orthotic or DME device can affect whether such claims are paid. HCFA issued Ruling 96-1 to clarify the circumstances under which certain items would be classified as orthotics or as DME for Medicare part B payment purposes. A federal appellate court found that HFCA had followed appropriate procedures to issue the rule as an interpretation of Medicare policy, the interpretation in the ruling was wholly supportable, and the treating of seating systems as DME was consistent with congressional intent. HCFA's ruling that attached bracing devices were in the DME benefits category and could no longer be billed as orthotics affects beneficiaries residing in Medicare-certified skilled nursing facilities and other institutions primarily engaged in providing skilled nursing care (SNF). Because Medicare part B does not cover DME in SNFs and other institutions primarily engaged in providing skilled nursing care, claims for such items are no longer paid for residents in nursing homes. If HCFA's ruling were rescinded and Medicare's policy changed so that attached bracing devices were classified as orthotics, how much Medicare and Medicaid would spend for orthotics is uncertain. The distinction between DME and orthotics would become less clear, which could lead to inappropriate billing. Therefore, if the ruling were rescinded, additional controls, such as closely monitoring billing and reviewing medical justification for customized items prior to payment, would be vital to help curb potentially inappropriate billing.

Medicare: Payments for Covered Outpatient Drugs Exceed Providers' Costs (GAO-01-1118, 21-SEP-01)

Physicians are able to obtain Medicare-covered drugs at prices significantly below current Medicare payments, which are set at 95 percent of average wholesale prices (AWP). The difference between these prices and AWP for physician-administered drugs in GAO's sample varied by drug. For most physician-administered drugs, the average discount from AWP ranged from 13 percent to 34 percent; two physician-administered drugs had discounts of 65 percent and 86 percent. Other suppliers are also able to buy drugs at prices that are considerably less than the AWP used to establish the applicable Medicare payment with discounts ranging from 78 percent to 85 percent below AWP for two drugs in the sample. Also, suppliers generally receive a payment from Medicare for the durable medical equipment needed to administer the drug and supplies. Private and other public payers use different payment methods for drugs and their administration. Private health plans use their drug-purchase and patient volume to negotiate favorable prices for drugs and physician and supplier services related to supplying or delivering the drugs. Other public payers also use

their purchasing volume along with information about actual transaction prices from private payers to lower their drug payments.

Medicare: Program Designed to Inform Beneficiaries and Promote Choice Faces Challenges (GAO-01-1071, 28-SEP-01)

The Balanced Budget Act of 1997 (BBA) established the Medicare+Choice (M+C) program to expand health plan choices. BBA permitted Medicare participation by preferred provider organizations, provider-sponsored organizations, and insurers offering private fee-for-service plans or medical savings accounts. It also encouraged the wider availability of health maintenance organizations, which have long been an option for many beneficiaries. To help beneficiaries understand and consider all of their Medicare options, the National Medicare Education Program offers a toll-free help line, informational mailings to beneficiaries, an Internet site, and educational and publicity campaigns. During fiscal years 1998 through 2000, the Health Care Financing Administration (HCFA) spent an average of $107.8 million on the program annually. Most of the money came from user fees collected from M+C plans. Reaction to the program has generally been positive among beneficiaries and beneficiary advocacy groups, but representatives of M+C plans offered a mixed assessment. Program activities have increased the information available to beneficiaries on Medicare, the M+C program, and specific health plans. However, the extent to which the program has motivated beneficiaries to actively weigh their health plan options is unknown.

Medicare: Utilization of Home Health Care by State (GAO-02-782R, 23-MAY-02)

This report discusses the variation in Medicare home health use across states. Using home health claims for the first 6 months of 2001 from the Centers for Medicare and Medicaid, GAO compiled statistics on home health users, home health visits, home health episodes, and the percentage of home health users with multiple episodes for each state. A home health episode, the basis for Medicare payment under the prospective payment system, is up to a 60-day period of care during which any number of visits may be provided.

Medicare + Choice: Recent Payment Increases Had Little Effect on Benefits or Plan Availability in 2001 (GAO-02-202, 21-NOV-01)

The number of contracts under Medicare's managed care program--Medicare+Choice (M+C)--fell from 340 to 180 between 1998 and 2001. The reduction reflected decisions by some managed care organizations (MCOs) to terminate selected contracts or to discontinue service in some covered areas. Although nearly all MCOs renewed at least some of their Medicare contracts over this period, many reduced the geographic areas served. As a result, 1.6 million beneficiaries had to switch MCOs or return to Medicare's traditional fee-for-service program. Other MCOs plan either to terminate or reduce their participation in M+C at the end of 2001. Concerned about MCO withdrawals, Congress sought to make participation in the program more attractive. As a result of the Benefits Improvement and Protection Act of 2000, aggregate Medicare+Choice payments in 2001 are estimated to have increased by $1 billion. The act permitted three basic uses for the higher payment. MCOs could (1) improve their health plans' benefit packages, (2) set aside money for future years in a benefit

stabilization fund, or (3) stabilize or enhance beneficiary access to providers. Most MCOs reported that additional money would be used to stabilize or enhance beneficiary access to providers. A minority of MCOs reported that the money would go toward benefit improvements or be placed in a benefit stabilization fund. In 83 percent of M+C plans, MCOs stated that some or all of the additional money would be used to stabilize or enhance beneficiary access. The payment increases had little effect on the availability of M+C plans during 2001. Following passage of the act, three MCOs reentered counties they had dropped from their service areas, three MCOs expanded into counties that they previously had not served, and one MCO both reentered previously served counties and expanded into new ones.

Medicare+Choice: Selected Program Requirements and Other Entities' Standards for HMOs (GAO-03-180, 31-OCT-02)

Since the early 1980s, health maintenance organizations (HMO) have entered into risk-based contracts with Medicare and offered beneficiaries an alternative to the traditional fee-for-service (FFS) program. By 1997, 5.2 million Medicare beneficiaries were enrolled in an HMO. Although Medicare HMOs were available in most urban areas, they were often unavailable in rural areas. Medicare+Choice (M+C) has HMO requirements pertaining to benefit package proposals, the beneficiary enrollment process, marketing and enrollee communication materials, and quality improvement, among other areas. An HMO must annually submit a benefit package proposal to the Centers for Medicare and Medicaid Services (CMS) for each M+C health plan that the HMO intends to offer. M+C requirements for the beneficiary enrollment process specify the information that an HMO must include in its enrollment application and the checks that it must perform to ensure that beneficiaries who submit applications are eligible to enroll in the HMO's health plan. M+C marketing requirements prohibit HMOs from using inaccurate or misleading language in advertisements or materials distributed to enrollees. M+C requirements for quality improvements specify that HMOs must undertake multiyear projects intended to improve the quality of health care and must routinely gather and report performance data to CMS.

Medicare Home Health: Clarifying the Homebound Definition Is Likely to Have Little Effect on Costs and Access (GAO-02-555R, 26-APR-02)

Medicare's home health benefit provides skilled nursing and other services to eligible beneficiaries who are homebound. The Department of Health and Human Services (HHS) had a long-standing policy that beneficiaries who regularly attend adult day care were not considered homebound, particularly if the purpose of attending was to receive nonmedical or custodial care. In 2000, Congress specified that Medicare beneficiaries who attended adult day care could be considered homebound if they still met the other homebound requirements. GAO found that this clarification will likely have little effect on program costs or access to services because the number of affected individuals is probably small. On the basis of National Long Term Care Survey data, GAO estimated that, as of 1999, 0.2 percent of elderly Medicare beneficiaries attended adult day care and had mobility or cognitive impairments that might make some eligible for Medicare home health services.

Medicare Home Health Agencies: Weaknesses in Federal and State Oversight Mask Potential Quality Issues (GAO-02-382, 19-JUL-02)

The 6,900 Home Health Agencies (HHAs) that serve Medicare beneficiaries must meet federal requirements, known as conditions of participation (COP), to ensure that they have the appropriate staff, are following the plan of care specified by a physician, maintain medical records to document the care provided, and periodically reassess each patient's condition. Although nationwide surveys done at HHAs since 1998 have identified a small proportion of agencies with serious deficiencies, the extent of the problem may be understated, and situations endangering the health and well being of home health patients may occur more often than documented. Shortcomings in the survey process and inconsistencies in state surveys make it difficult to assess the quality of care delivered and may mask potential problems. The ability to lodge complaints about an HHA and have them resolved promptly is important to protecting patient health and safety. HHA oversight by the Centers for Medicare and Medicaid Services (CMS) has been too limited to identify the problems GAO found in the survey process. CMS does not review state compliance with requirements for conducting HHA surveys, such as whether HHAs with COP-level deficiencies are surveyed annually rather than every 3 years or whether minimum patient visit and medical record review samples are adhered to.

Medicare Home Health Care: OASIS Data Use, Cost, and Privacy Implications (GAO-01-205, 30-JAN-0)

With the Health Care Financing Administration's (HCFA) implementation of a prospective payment system, efforts to protect patients from potential underprovision of care and to hold home health agencies (HHA) accountable are essential. Instituting the collection and reporting of Outcome and Assessment Information Set (OASIS) data is an important step in that direction. The use of OASIS data enhances consistency in the performance and documentation of patient assessments for home health services. As a result, information on patient outcomes will become available for the first time. Collecting such data is not without its costs. To varying degrees, the requirement to collect OASIS data on all home health patients increases the amount of staff time devoted to collecting and reporting patient assessment information. HHAs have been compensated for some of these costs through adjustments made to their payment rates. Moreover, because prospective payment system episode payment rates are based on historically high utilization levels, which have since declined, these rates should allow the completion of OASIS assessments. Protecting the privacy of home health care patients is also important. HCFA has made progress in this area by enhancing protections in the collection and transmission of the OASIS data. The effectiveness of these policies and procedures will depend on how well they are implemented.

Medicare Home Health Care: Payments to Home Health Agencies Are Considerably Higher than Costs (GAO-02-663, 06-MAY-02)

The Balanced Budget Act of 1997 significantly changed Medicare's home health care payments to home health agencies (HHAs). Under a prospective payment system (PPS),

HHAs are paid a fixed amount, adjusted for beneficiary care needs, for providing up to 60 days of care—termed a "home health episode." The act also imposed new interim payment limits to moderate spending until the PPS could be implemented. Although PPS was designed to lower Medicare spending below what it was under the interim system, GAO found that Medicare's payments for full home health care episodes were 35 percent higher than estimated costs in the first six months of 2001. These disparities indicate that Medicare's PPS overpays for services actually provided, although some HHAs facing extraordinary costs not accounted for by the payment system may be financially disadvantaged.

Medicare Physician Fee Schedule: Practice Expense Payments to Oncologists Indicate Need For Overall Refinements (GAO-02-53, 31-OCT-01)

Medicare's physician fee schedule establishes payments for more than 7,000 different services, such as office visits, surgical procedures, and treatments. Before 1992, fees were based on charges physicians billed for these services. Since then, the Health Care Financing Administration (HCFA), which administers Medicare, has been phasing in a new fee schedule on the basis of the amount of resources used to provide that service relative to other services. The development of the resource-based practice expense component of the fee, which is intended to pay for the costs of running a physician's practice, has been particularly controversial. HCFA adjusted the underlying data and basic method for calculating resource-based practice expense payments and payment changes were required to be budget-neutral—which means that total Medicare spending for physician services was to be the same under the new payment method as it was under the old one. As a result, Medicare payments to some specialties have increased while payments to other specialties have decreased. Oncologists claim that their practice expense payments are particularly inadequate for some office-based services, such as chemotherapy. Oncology practice expense payments in 2001 are eight percent higher than they would have been had charged-based payments continued. Oncology practice expense payments compared to their estimated practice expenses are about the same as the average for all physicians. HCFA's adjustments to the data and basic method reduced payments to oncologists.

Medicare Physician Payments: Medical Settings and Safety of Endoscopic Procedures (GAO-03-179, 18-OCT-02)

Every year millions of Americans covered by Medicare undergo endoscopic medical procedures in a variety of health care settings ranging from physicians' offices to hospitals. These invasive procedures call for the use of a lighted, flexible instrument and are used for screening and treating disease. Although some of these procedures can be performed while the patient is fully awake, most require some form of sedation and are usually provided in health care facilities such as hospitals or ambulatory surgical centers. Some physician specialty societies have expressed concern that Medicare's reimbursement policies may offer a financial incentive to physicians to perform endoscopic procedures in their offices and that these procedures may be less safe because physicians' offices are less closely regulated and therefore there is less oversight of the quality of care. For the 20 procedures reviewed, there was no evidence to suggest that there was any difference in the level of safety of

gastroenterological and urological endoscopic procedures performed on Medicare beneficiaries in either physicians' offices or health care facilities, such as hospitals and ASC's. There was also no evidence found to suggest that the resource-based site-of-service payment differential has caused physicians to conduct a greater proportion of gastroenterological or urological endoscopic procedures in their offices for Medicare beneficiaries. If Medicare coverage for the office procedures in the study were terminated, few access problems would occur in most of the country because physicians perform the vast majority of the procedures that were studied in health care facilities.

Medigap Insurance: Plans Are Widely Available but Have Limited Benefits and May Have High Costs (GAO-01-941, 31-JUL-01)

To protect themselves against large out-of-pocket expenses and help fill gaps in Medicare coverage, most beneficiaries buy supplemental insurance, known as Medigap; contribute to employer-sponsored health benefits to supplement Medicare coverage; or enroll in private Medicare+Choice plans rather than traditional fee-for-service Medicare. Because Medicare+Choice plans are not available everywhere and many employers do not offer retiree health benefits, Medigap is sometimes the only supplemental insurance option available to seniors. Medicare beneficiaries who buy Medigap plans have coverage for essentially all major Medicare cost-sharing requirements, including coinsurance and deductibles. Although various proposals have been made to add a prescription drug benefit to Medicare, relatively few beneficiaries buy standardized Medigap plans with this benefit. Low enrollment in these plans may be due to the fact that fewer plans are being marketed with these benefits; their relatively high cost; and the limited nature of their prescription drug benefit, which still requires beneficiaries to pay more than half of their prescription drug costs. Most plans offering this coverage have a $3,000 cap on prescription drug benefits. As a result, Medigap beneficiaries with prescription drug coverage continue to incur substantial out-of-pocket expenses for prescription drugs and other health care services.

Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities (GAO-02-279, 15-FEB-02)

Nursing homes that participate in Medicare and Medicaid must periodically assess the needs of residents in order to develop an appropriate plan of care. Such resident assessments are known as the minimum data set (MDS). According to officials in the 10 states with MDS accuracy review programs in operation as of January 2001, these programs were established because of the important role played by MDS data in setting Medicaid payments and identifying quality of care problems. Nine of the 10 states conduct periodic on-site reviews in all or a significant portion of their nursing homes to assess the accuracy of the MDS data. These reviews sample a home's MDS assessments to determine whether the basis for the assessments is adequately documented in residents' medical records. These reviews often include interviews of nursing home personnel familiar with residents and observations of the residents themselves. States with separate MDS review programs identified various approaches to improve MDS accuracy. State officials highlighted the on-site review process itself and provider education activities as their primary approaches. State officials also reported such remedies as requiring nursing homes to prepare a corrective action plan or

imposing financial penalties on nursing homes when serious or extensive errors in MDS data are found.

Following the 1998 implementation of Medicare's MDS-based payment system the Federal government began building the foundation for its own separate review program to ensure the accuracy of MDS data. In the course of developing and testing various accuracy review approaches, widespread MDS errors were found that resulted in a change in the Medicare payment level for two-thirds of the resident assessments sampled. On site visits proved to be a very effective method of assessing accuracy. However as currently planned, federal MDS review activities are projected to involve roughly 1 percent of the estimated 14.7 million MDS assessments expected to be completed with on site reviews in fewer than 200 of the nations 17,000 nursing homes each year. While the federal approach may yield some broad sense of the accuracy of MDS assessments on an aggregate level, it appears to be insufficient to provide confidence about the accuracy of MDS assessments in the vast bulk of nursing homes nationwide. Given the substantial level of effort and resources already invested at the state and federal levels to oversee nursing home quality of care, including periodic inspections at each home nationwide, we recommend that CMS reorient its MDS accuracy program so that it complements and leverages existing state review activities and its own established nursing home oversight efforts.

Nursing Homes: More Can Be Done to Protect Residents from Abuse (GAO-02-312, 01-MAR-02)

Often suffering from multiple physical and mental impairments, the 1.5 million elderly and disabled Americans living in nursing homes are a highly vulnerable population. These individuals typically require extensive help with daily living, such as such as dressing, feeding, and bathing. Many require skilled nursing or rehabilitative care. In recent years, reports of inadequate care, including malnutrition, dehydration, and other forms of neglect, have led to mounting scrutiny from state and federal authorities, which share responsibility for overseeing the nation's 17,000 nursing homes. Concerns have also been growing that some residents are abused—pushed, slapped, or beaten—by the very individuals to whom their care has been entrusted. GAO found that allegations of physical and sexual abuse of nursing home residents are not reported promptly. Local law enforcement officials said that they are seldom summoned to nursing homes to immediately investigate allegations of abuse and that few allegations are ever prosecuted. Some agencies use different policies when deciding whether to refer allegations of abuse to law enforcement. As a result, law enforcement agencies were never told of some incidents or were notified only after lengthy delays. GAO found that federal and state safeguards intended to protect nursing home residents from abuse are inadequate. No federal statute requires criminal background checks for nursing home employees. Background checks are also not required by the Centers for Medicare and Medicaid Services, which sets the standards that nursing homes must meet to participate in the Medicare and Medicaid programs. State agencies rarely recommend that sanctions be imposed on nursing homes. Although state agencies compile lists of aides who have previously abused residents, which can prevent an aide from being hired at another nursing home, GAO found that delays in making these identifications can limit the usefulness

of these registries. GAO summarized this report in testimony before Congress; see GAO-02-448T.

Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature (GAO-03-187, 31-OCT-02)

GAO was asked to review the Centers for Medicare & Medicaid Services (CMS) initiative to publicly report additional information on its "Nursing Home Compare" Web site intended to help consumers choose a nursing home. GAO examined CMS's development of the new nursing home quality indicators and efforts to verify the underlying data used to calculate them. GAO also reviewed the assistance CMS offered the public in interpreting and comparing indicators available in its six-state pilot program, launched in April 2002, and its own evaluation of the pilot. The new indicators are scheduled to be used nationally beginning in November 2002.

CMS's initiative to augment existing public data on nursing home quality has considerable merit, but its planned November 2002 implementation does not allow sufficient time to ensure the indicators are appropriate and useful to consumers. CMS's plan urges consumers to consider nursing homes with positive quality indicator scores, in effect, attempting to use market forces to encourage nursing homes to improve the quality of care. However, CMS is moving forward without adequately resolving important open issues on the appropriateness of the indicators chosen for national reporting or the accuracy of the underlying data. To develop and help select the quality indicators, CMS hired two organizations with expertise in health care data—Abt Associates, Inc. and the National Quality Forum (NQF). Abt identified a list of potential quality indicators and tested them to verify that they represented the actual quality of care individual nursing homes provide. GAO's review of the available portions of the report raised serious questions about the basis for moving forward with national reporting at this time. NQF, which was created to develop and implement a national strategy for measuring health care quality, was hired to review Abt's work and identify core indicators for national reporting. To allow sufficient time to review Abt's validation report, NQF agreed to delay its recommendations for national reporting until 2003. CMS limited its own evaluation of its six-state pilot program for the initiative so that the November 2002 implementation date could be met. Early results were expected in October 2002, leaving little time to incorporate them into the national rollout. Despite the lack of a final report from NQF and an incomplete pilot evaluation, CMS has announced a set of indicators it will begin reporting nationally in November 2002. GAO has serious concerns about the potential for public confusion by the quality information published, especially if there are significant changes to the quality indicators due to the NQF's review. CMS's proposed reporting format implies a precision in the data that is lacking at this time. While acknowledging this problem, CMS said it prefers to wait until after the national rollout to modify the presentation of the data. GAO's analysis of data currently available from the pilot states demonstrated there was ample opportunity for the public to be confused, highlighting the need for clear descriptions of the data's limitations and easy access to impartial experts hired by CMS to operate consumer hotlines. CMS has not yet demonstrated its readiness to meet these consumer needs either directly or through the hotlines fielding public questions about confusing or conflicting quality data. CMS acknowledged that further work is needed to refine its initiative, but

believes that its indicators are sufficiently valid, reliable, and accurate to move forward with national implementation in November 2002 as planned.

Nursing Homes: Quality of Care More Related to Staffing than Spending (GAO-02-431R, 13-JUN-02)

Costs for nursing home care have almost doubled since 1990, from $53 billion to $92 billion in 2000. Much of that spending has been financed with public monies. Under the Medicare and Medicaid programs, the federal government financed 39 percent of the nation's nursing home spending in 2000, up from 28 percent in 1990. As federal outlays have grown, Congress has focused attention on the quality of care delivered and the level of staffing in nursing homes. GAO surveyed three states and found that nursing home expenditures per resident day varied considerably across Ohio, Mississippi, and Washington. Although the total level of spending varied, the average share devoted to resident-care activities, such as nursing care and medical supplies, was relatively stable. The share of spending devoted to buildings and equipment, by comparison, was more variable. Homes in Ohio and Washington that provided more nursing hours per resident day, especially nurses' aide hours, were less likely than homes providing fewer nursing hours to have repeated serious or potentially life-threatening quality problems. However, GAO found no clear relationship between a nursing home's spending per resident day and the number of serious quality problems.

Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors (GAO-01-944, 10-JUL-01)

The nation's hospitals and nursing homes rely heavily on the services of nurses. Concerns have been raised about whether the current and projected supply of nurses will meet the nation's needs. This report reviews (1) whether evidence of a nursing shortage exists, (2) the reasons for current nurse recruitment and retention problems, and (3) what is known about the projected future supply of and demand for nurses. GAO found that national data are not adequate to describe the nature and extent of nurse workforce shortages, nor are data sufficiently sensitive or current to compare nurse workforce availability across states, specialties, or provider types. Multiple factors affect recruitment and retention problems, including the aging of the nurse workforce, resulting from reduced entry of younger people into the profession and nurses' job dissatisfaction. A serious shortage of nurses is expected in the future as demographic pressures influence both demand and supply.

Private Health Insurance: Access to Individual Market Coverage May Be Restricted for Applicants with Mental Disorders (GAO-02-339, 28-FEB-02)

About five percent of adults suffer from serious mental disorders. Although health insurance carriers in 11 states guarantee coverage for mental health treatment, in most states individuals with mental disorders face restrictions in purchasing private health insurance for themselves and their families. Eleven states require carriers to accept all applicants regardless of health status, but coverage options vary. Eight of these 11 states require all carriers to guarantee access to coverage sold in this market. In three states, laws apply only to some carriers, such

as Blue Cross and Blue Shield, or certain periods of the year. Carriers in nine of the 11 states are also required to limit the extent to which premium rates vary between healthy and unhealthy individuals. In states without guaranteed coverage in the individual market, the seven carriers GAO reviewed would likely deny coverage more frequently for applicants with mental disorders than for applicants with other chronic health conditions. Specifically, for six mental disorders of generally moderate severity, carriers said that they would likely decline applicants 52 percent of the time. State-sponsored high-risk pools are the primary coverage option available to rejected applicants in most states. In 27 of the 34 states where carriers may deny coverage to applicants with mental disorders or other health conditions, high-risk pools offer coverage to applicants denied individual market coverage. The pools are subsidized—generally through assessments on carriers or state tax revenues—and premium rates are generally capped at 125 to 200 percent of standard rates for healthy individuals. Health benefits available under the pools are generally comparable to those available in the individual market, including similar restrictions on mental health benefits; however, benefits for mental disorders or other health conditions are not permanently excluded as they may be in the individual insurance market.

Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion (GAO-01-374, 01-MAY-01)

In 1999, about 10 million retired people aged 55 or older relied on employer-sponsored health insurance as either their primary source of coverage or as a supplement to their Medicare coverage. Some of these persons are concerned about the continued availability of employer-sponsored coverage. Premium increases and forecasts for a potential economic slowdown could further erode employer-sponsored retired health benefits. In the long term, these factors, coupled with the potential for Medicare reforms and the rising number of aging baby boomers, may produce even more uncertainty and cost pressures for employers. Consequently, as an increasing number of retirees lack employer-based coverage, those in poorer health may have difficulty finding affordable alternative health coverage.

Retiree Health Benefits: Examples of Employer-Reported Obligations in Selected Industries (GAO-02-639R, 29-APR-02)

In addition to providing an overview of a company's business operations, the annual reports submitted to the Securities and Exchange Commission present important information on an employer's estimated obligations for postemployment benefits, including retiree health benefits. However, the assumption used to estimate obligations for postemployment benefits vary across companies and are not comparable. Financial Accounting Standards Board guidelines give employers latitude in calculating these obligations. Moreover, changes in companies' benefit offerings or financial stability would likely alter companies' obligations for retiree health benefits. Most employers also reserve the right to change or terminate retiree health benefits.

Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase (GAO-03-176, 13-NOV-02)

The nation's 15,000 skilled nursing facilities (SNF) play an essential role in our health care system, providing Medicare-covered skilled nursing and rehabilitative care each year for 1.4 million Medicare patients who have recently been discharged from acute care hospitals. In recent years, many analysts and other observers, including members of Congress, have expressed concern about the level of nursing staff in SNFs and the impact of inadequate staffing on the quality of care. The Congress temporarily increased the nursing component of the SNF Medicare payment rate by 16.6 percent. GAO's analysis of available data shows that, in the aggregate, SNFs' nurse staffing ratios changed little after the increase took effect. Overall, SNFs' average nursing time increased by 1.9 minutes per patient day, relative to their average in 2000 of about 3 and one-half hours of nursing time per patient day. For most SNFs, increases in staffing ratios were small. Further, GAO found that the share of SNF patients covered by Medicare was not a factor in whether facilities increased their nursing time. Similarly, SNFs that had total revenues considerably in excess of costs before the added payments took effect did not increase their staffing substantially more than others.

Skilled Nursing Facilities: Medicare Payments Exceed Costs for Most but Not All Facilities (GAO-03-183, 31-DEC-02)

This report addresses (1) the relationship between Medicare skilled nursing facility (SNF) payments and the costs of treating Medicare patients in freestanding SNFs, as well as the effect of Medicare SNF payments on the financial condition of these facilities, and (2) the relationship between Medicare SNF payments and the costs of treating patients in hospital-based SNFs, as well as the factors that may account for cost differences between hospital-based and freestanding SNFs.

Under the prospective payment system (PPS), most freestanding SNFs' Medicare payments substantially exceeded the costs of caring for Medicare patients, contributing to facilities' overall positive financial condition. In 1999, the first full year under the PPS, the median freestanding SNF Medicare margin—a measure that compares Medicare payments with Medicare costs—was slightly over 8 percent. By 2000, when the temporary payment increases authorized by the Congress started to take effect, the median Medicare margin had risen to almost 19 percent. However, nearly one-quarter of SNFs in 2000 had Medicare margins exceeding 30 percent, while about one-fifth had negative Medicare margins; that is, the payments they received from Medicare did not cover their costs of providing care. Medicare margins were higher for freestanding SNFs affiliated with large, for-profit nursing home chains and for those with high occupancy. The median SNF total margin—which reflects total revenues and costs across all patients—was 1.3 percent in 1999 and 1.8 percent in 2000. A SNF's total margin tended to be higher when its Medicare margin was higher despite the fact that, in most SNFs, Medicare's share of patient days was small. The total margins for freestanding SNFs tended to be lower when a higher proportion of a SNF's patients had their care paid for by Medicaid. Unlike freestanding SNFs, about 90 percent of hospital-based SNFs reported significantly negative Medicare margins after Medicare's new SNF payment system was launched. The median hospital-based SNF Medicare margin was -53 percent in 1999. Under the PPS, per diem payments to hospital-based SNFs dropped considerably, reflecting the change from payments based on a facility's own costs to fixed payments based on average costs for all facilities. At the same time, hospital-based SNFs

reported per diem costs rose from 1997 through 1999. This is in contrast to the experience of freestanding SNFs, which had lower per diem Medicare costs than hospital-based SNFs prior to the PPS and reduced their costs further after the shift to the PPS. The higher Medicare costs reported by hospital-based SNFs may stem in part from differences in services provided to patients. The higher costs may also reflect the historical allocation of overhead costs to the SNF from the hospital, an accounting practice that, while consistent with the payment incentives under the prior cost-based reimbursement system, means that hospital-based SNFs reported costs should be treated cautiously.

Skilled Nursing Facilities: Providers Have Responded to Medicare Payment System By Changing Practices (GAO-02-841, 23-AUG-02)

In 1998, the Health Care Financing Administration implemented a prospective payment system (PPS) for skilled nursing facility (SNF) services provided to Medicare beneficiaries. The PPS is intended to control the growth in Medicare spending for skilled nursing and rehabilitative services that SNFs provide by providing a predetermined payment for each day of care. The payment varies depending on the patient's payment group classification, which reflects expected resource use, but not the actual resource use. Two years after the implementation of the PPS, the mix of patients across the payment groups has shifted, as determined by the patients' initial assessments. More patients were classified into the high and medium rehabilitation payment group categories, which were believed to be the most profitable, and fewer were initially classified into the most intensive (highest paying) and least intensive (lowest paying) rehabilitation payment group categories. The majority of patients in rehabilitation payment groups received less therapy than was provided in 1999. This was true even for patients within the same rehabilitation payment group categories. Across all rehabilitation payment group categories, fewer patients received the highest amounts of therapy associated with each payment group.

Skilled Nursing Facilities: Services Excluded From Medicare's Daily Rate Need to be Reevaluated (GAO-01-816, 22-AUG-01)

Congress and the Health Care Financing Administration recognized that certain services needed to be excluded from the skilled nursing facility (SNF) prospective payment system (PPS) rate to help ensure beneficiary access to appropriate care and to financially protect the SNFs that take care of high-cost patients. The criteria used to identify services—high cost, infrequently provided during a SNF stay and likely to be overprovided--and the services currently excluded appear reasonable. Even so, questions remain about whether certain other services should be excluded and how to modify the exclusions over time. Current exclusion policies raise three unintended consequences—beneficiary liability is higher for excluded services; beneficiaries may be required to receive excluded services in only certain facilities, which may be higher cost; and the broad definition of excluded emergency services may result in more care being classified as emergency. The Centers for Medicare & Medicaid Services (CMS) does not plan to collect data on all services provided to beneficiaries during their SNF stays. Without these data, CMS will have difficulty updating the exclusions over time and limit efforts to refine the payment system.

Title III, Older Americans Act: Carryover Funds Are Not Creating a Serious Meal Service Problem Nationwide (GAO-01-211, 09-JAN-01)

Under Title III of the Older Americans Act, the Administration on Aging (AoA) distributes grants to states on the basis of their proportional share of the total elderly population in the United States. Most states then disburse these grants to more than 600 area agencies nationwide. The grants are further subdivided by these agencies to more than 4,000 local service providers and are used to fund group and in-home meals, as well as support services, including transportation and housekeeping. AoA requires that states obligate these funds by September 30 of the fiscal year in which they are awarded. Also, states must spend this money within two years after the fiscal year in which it is awarded. During this time AoA does not limit or monitor the amount of unspent funds that states may carry over to the succeeding fiscal year. GAO examined whether states were using Title III carryover funds to expand their meal service programs for the elderly beyond a level sustainable by their annual allotments alone. GAO found that the buildup and use of Title III carryover funds to support elderly nutrition services does not appear to be a widespread problem. However, AoA does not monitor the states' buildup of carryover funds. As a result, the agency has little assurance that it could identify meal service problems that could emerge in the future.

INCOME SECURITY ISSUES

Answers to Key Questions about Private Pension Plans (GAO-02-745SP, 18-SEP-02)

This primer on private pensions provides information on the basic features of the private pension plan system and the federal framework that governs how private plans must operate. GAO answers questions about the types of plans that private employers may sponsor, the benefits these plans provide, and the basic requirements that govern how these plans are administered.

Older Workers: Demographic Trends Pose Challenges for Employers and Workers (GAO-02-85, 16-NOV-01)

The impending retirement of the "baby boom" generation is receiving considerable attention. The number of older workers will grow substantially during the next two decades, and they will become an increasingly significant share of the U.S. workforce. For example, according to the 2001 Current Population Survey, there were 17.3 million workers over age 55 in the laborforce, and this number is expected to increase to 25.3 million or over 20 percent of the laborforce in 2015. Although older workers are less likely than younger workers to lose a job, when they do lose a job, they are less likely than younger workers to find other employment. To retain older workers and extend their careers, some public and a few private employers are providing options, including flexible hours and financial benefits, reduced workloads through the use of part-time or part-year schedules, and job-sharing. Most employers are not yet facing labor shortages or other economic pressures that would require them to consider flexible employment arrangements because the retirement of the baby boom generation will occur gradually during the next several decades.

Private Pensions: Improving Worker Coverage and Benefits (GAO-02-225, 09-APR-02)

Although pensions are an important source of income for many retirees, millions of workers lack individual pension coverage. Only half of the nation's workers have been covered by private employer-sponsored pensions since the 1970s. Traditional reforms to the voluntary, single-employer-based pension system have limited potential to expand pension coverage and improve worker benefits. These pension reforms have concentrated mainly on improving tax incentives and reducing the regulatory burden on small employers. Furthermore, efforts to increase retirement savings by restricting the use of lump-sum distributions could limit worker participation in and contributions to pension plans. Three categories of reform—pooled employer reforms, universal access reforms, and universal participation reforms—go beyond the voluntary, single-employer private pension system. Pooled employer reforms seek to increase the number of firms offering pension coverage by creating centralized third-party administration and increasing pension plan portability. Universal access reforms seek to boost savings by offering payroll-based accounts, albeit without mandating employer contributions. Universal participation reforms would mandate pension availability and participation for all workers, similar to the existing Social Security system.

Private Pensions: IRS Can Improve the Quality and Usefulness of Compliance Studies (GAO-02-353, 12-APR-02)

The Internal Revenue Service (IRS) studied 401(k) plan compliance with Internal Revenue Code requirements for tax-qualified plans. GAO found that IRS's estimates of noncompliance were inaccurate. The study, which audited a sample of 401(k) plans, did not provide information on the severity of the compliance violations identified and did not determine the number of plan participants or the amount of assets associated with noncompliance errors. Only 27 of the 73 study questions identified as compliance indicators conclusively demonstrated whether a plan was compliant or not. Consequently, the 44 percent reported to have one or more instances of noncompliance is at best an upper limit on the extent of noncompliance found. IRS has chosen specific types of private pension plans to study in a manner similar to the one conducted on 401(k) pension plans. The data that IRS collects will be analyzed to determine the prevalence and types of noncompliance among the plans studied.

Private Pensions: Issues of Coverage and Increasing Contribution Limits for Defined Contribution Plans (GAO-01-846, 17-SEP-01)

Proposals to expand pension coverage and promote pension savings have recently received much attention. In the Economic Growth and Tax Relief Reconciliation Act of 2001, for example, Congress raised statutory limits on tax-deferred pension contributions and benefits and made other changes to the law governing qualified pension plans. Some believe that increasing these limits will encourage employers to start new plans and improve existing plan coverage, especially for employees of small businesses. Others contend that these measures will primarily benefit higher-paid individuals and may not improve pension coverage for low-or moderate-income workers. Forty-seven percent of all workers participated in a pension plan, and 36 percent of all workers participated in a defined contribution (DC) plan. Most pension plan participants had low or moderate earnings (less than $40,000 per year) and were men. About eight percent of all DC participants, or 3.1 million people, were likely direct beneficiaries of a simultaneous increase in all the statutory contribution limits GAO analyzed. Higher earners were more likely than low and moderate earners, and men were more likely than women, to benefit directly from such an increase; this was also true of increases in each of the separate dollar limits on contributions. About 721,000 DC participants, or 11 percent of eligible DC participants, were likely to benefit from a so-called "catch-up" provision allowing persons aged 50 or older to make additional contributions to DC plans. Higher earners were more likely to benefit directly from this option than were low and moderate earners. However, neither male more female DC participants were significantly more likely to benefit directly from this option.

Private Pensions: Participants Need Information on the Risks of Investing in Employer Securities and the Benefits of Diversification (GAO-02-943, 06-SEP-02)

The financial collapse of large firms and the effects on workers and retirees has raised questions about retirement funds being invested in employer securities and the laws governing such investments. Pensions are important source of income of many retirees, and the federal government has encouraged employers to sponsor and maintain pension and savings plans for their employees. The continued growth in these plans and their vulnerabilities has caused Congress to focus on issues related to participants investing in employer securities through employer-sponsored retirement plans. GAO's analysis of the 1998 plan data for the Fortune 1,000 firms showed that 550 of those companies held employer securities in their defined benefit plans or defined contribution plans, covering 13 million participants. Investment in employer securities through employer-sponsored retirement plans can present significant risks for employees. If the employees' retirement savings is largely in employer securities in these plans, employees risk losing not only their jobs should the company go out of business, but also a significant portion of their savings. Even if employers do not declare bankruptcy, employees are still subject to the dual risk of loss of job and loss of retirement savings because corporate losses and stock price declines can result in companies significantly reducing their operations. Under the Employee Retirement Income Security Act and the Securities Acts, the Department of Labor and Securities and Exchange Commission (SEC) are responsible for ensuring that certain disclosures are made to plan participants regarding their investments. Although employees in plans where they control their investments receive disclosures under the act regarding their investments, such regulations do not require companies to disclose the importance of diversification or warn employees about the potential risks of owning employer securities. SEC requires companies with defined contribution plans that offer employees an opportunity to invest in employer stock to register and disclose to SEC specific information about those plans. In addition, in most cases the underlying securities of those plans must be registered with SEC. However, SEC does not routinely review these company plan filings because pension plans generally fall under other federal regulation.

Retirement Savings: Opportunities to Improve DOL's SAVER Act Campaign (GAO-01-634, 26-JUN-01)

Many of today's workers may not be financially prepared for retirement when they stop working. Many people are counting on Social Security alone, without an additional retirement plan. The Savings Are Vital to Everyone's Retirement (SAVER) Act of 1997 requires the Department of Labor (DOL) to hold periodic national summits and run an outreach program to promote retirement saving. This report
(1) identifies major accomplishments of the 1998 summit and issues that might affect future summits, (2) describes DOL's outreach program, and (3) determines what DOL knows about the effectiveness of the summit and outreach program. GAO found that the 1998 National Summit made progress in identifying problems that workers face in saving for retirement. DOL's Outreach Program--the Retirement Savings Education Campaign--targets of small business owners, women, minorities, and youth to change the way they think about, and act on, their retirement saving needs. DOL has not tried to assess the extent to which outreach

efforts from the 1998 National Summit and Pension and Welfare Benefits Administration have increased the public's knowledge and understanding of retirement savings.

Social Security: Program's Role in Helping Ensure Income Adequacy (GAO-02-62, 30-NOV-01)

Before Social Security, being old often meant being poor. Today, dependency on public assistance has dropped to a fraction of its Depression-era levels, and poverty rates among the elderly are now lower than for the population as a whole. At the same time, Social Security has become the single largest source of retirement income for more than 90 percent of persons aged 65 and older. Automatic adjustments were introduced in 1972 to reflect increases in the cost of living. Other program changes gradually increased social security coverage to larger portions of the workforce and extended eligibility to family members and disabled workers. Other benefit programs, such as Supplemental Security Income (SSI), Medicare, and Medicaid, have also been added over the years. With regard to measuring income adequacy, various measures help examine different aspects of this concept, but no single measure can provide a complete picture. For various subgroups of beneficiaries that have lower lifetime earnings, poverty rates have also declined. Although the Social Security benefit formula favors lower lifetime earners, their lower earnings and work histories can leave them with incomes below the poverty level when they retire or become disabled. The outlook for future Social Security benefit levels and income adequacy depend on how the program's long-term financing imbalance is addressed, as well as on the measures used. GAO concludes that reductions in promised benefits and increases in program revenues will be needed to restore the program's long-term solvency and sustainability. Possible benefit changes might include adjustments to the benefit formula or reductions in cost-of-living increases. Possible revenue sources might include higher payroll taxes or transfers from the Treasury's general fund.

Social Security Administration: Information Systems Could Improve Processing Attorney Fee Payments in Disability (GAO-01-796, 29-JUN-01)

To ensure that people claiming disability insurance benefits can obtain legal representation at a fair price, the Social Security Act requires that the Social Security Administration (SSA) regulate the fees that attorneys charge people to represent their disability claims before the agency. Inefficiencies in the current process increase both the time it takes to pay the attorney fees and the costs of administration. One segment of attorney fee processing—the fee approval process—was substantially simplified in 1991. Systems support could streamline the second segment of the processing—the fee payment—thus lowering the annual administrative costs and cutting processing time. By automating this final segment of the fee processing, SSA could help improve customer service for both claimants and their attorneys. GAO found that despite internal recommendations for a new system, SSA has repeatedly postponed its plans to improve the attorney fee payment process. Indeed, even though these improvements have been part of SSA's system's plans since 1998, SSA has yet to establish a firm schedule for carrying out its plans. Additionally, although SSA has a draft plan for improving the process, agency officials told GAO that the details of the plan have not been completed and SSA has yet to complete a cost estimate for the project. There are also other

gaps in the plan--such as not creating an attorney master file or establishing an electronic connection between the payment processing staff and the Office of Hearings and Appeals fee approval staff—where taking additional actions could improve the process. Furthermore, SSA's performance plan did not have goals related to attorney fees—neither for cost reduction of the program nor payment timeliness. SSA would need such goals as part of its current planning effort for improving the attorney fee payment process as well as for its future operations. Without such quantifiable goals, future efforts to track and oversee SSA's progress in these areas will be difficult.

Social Security Administration: Revision to the Government Pension Offset Exemption Should Be Reconsidered (GAO-02-950, 15-AUG-02)

Social Security benefits are payable to the spouses of retired, disabled, or deceased workers. The benefits often provide income to wives and husbands who have little or no Social Security benefits of their own. Until 1977, workers receiving pensions from government positions not covered by Social Security could receive their full pension benefit and their full spousal benefits as if they were nonworking spouses. Since then, a government pension offset has been in effect to equalize the treatment of workers covered by Social Security and those with noncovered government benefits. This report was prompted by a referral to GAO's Fraudnet that questioned a practice in which individuals in Texas were transferring to Social Security-covered positions for one day to avoid the offset. GAO found no central data on the use of the offset exemption by individuals, and time constraints did not permit in-depth audit work on the 2,300 state and local government retirement plans. However, GAO did establish that, as of June 2002, more than 4,800 persons in Texas and Georgia worked for brief periods in jobs covered by Social Security to qualify for the "last-day exemption." GAO estimates that the long-term Social Security payments to these individuals could be as high as $450 million. Such abuses of the offset exemption could be prevented by (1) changing the last-day provision to a longer minimum time period or (2) using a proportional approach based on the number of working years as a government employee spent in covered and noncovered employment to determine the extent to which the government pension offset applies.

SSA Disability: SGA Levels Appear to Affect the Work Behavior of Relatively Few Beneficiaries, but More Data Needed (GAO-02-224, 16-JAN-02)

The Social Security Administration's (SSA) Disability Insurance (DI) program paid $50 billion in cash benefits to more than five million disabled workers in 2000. Eligibility for DI benefits is based on whether a person with a severe physical or mental impairment has earnings that exceed the Substantial Gainful Activity (SGA) level. SSA terminates monthly cash benefit payments for beneficiaries who return to work and have earnings that exceed the SGA level—$1,300 per month for blind beneficiaries and $780 per month for all other beneficiaries. GAO found that the SGA level affects the work patterns of only a small proportion of DI beneficiaries. However, GAO also found that the SGA may affect the earnings of some beneficiaries. About 13 percent of those beneficiaries with earnings near the SGA level in 1985 still had earnings near the SGA level in 1995, even though the level was increased during that period. The absence of key information identifying the monthly

earnings of beneficiaries, their trial work period status, and whether they are blind limited GAO's ability to definitively identify a relationship between SGA levels and beneficiaries' work patterns. Data limitations also make the effect of the SGA on DI program entry and exit rates difficult to isolate. Although the rate of program entry increased in the years immediately following a 1990 increase in the SGA level, it then gradually declined to a level below the pre-1990 entry rates. Since 1990, DI exit rates continue to be driven largely by beneficiary death and conversion to retirement benefits. However, the percentage of all exits caused by improvements in medical conditions or a return to work increased slowly, from 1.9 percent in 1985 to 9.2 percent in 1996, and then rose dramatically to 19.9 percent in 1997. A substantial increase in the number of continuing disability reviews done by SSA may account, in part, for this 1997 upturn, but data limitations preclude GAO from obtaining a full understanding of the link between the SGA and exit behavior.

Social Security Programs: Scope of SSA's Authority to Deny Benefits to Fugitive Felons and to Release Information About OASI and DI Beneficiaries Who Are Fugitive Felons (GAO-02-459R, 27-FEB-02)

In response to concerns that individuals wanted in connection with a felony or violating terms of their parole or probation could receive benefits from programs for the needy, the Congress added provisions to the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 that prohibit these individuals from receiving Supplemental Security Income (SSI), Food Stamps benefits, Temporary Assistance for Needy Families (TANF), and federal housing assistance. To assist in the apprehension of fugitive felons, PRWORA also directs these programs to provide law enforcement agencies with information about program recipients for whom there are outstanding warrants. GAO was asked to determine if SSA has the authority under these provisions (1) to deny Old Age and Survivors Insurance (OASI) and Disability Insurance (DI) to fugitive felons, and (2) to give law enforcements agencies the current addresses and Social Security numbers of OASI or DI recipients who are fugitive felons. GAO found that SSA currently lacks the authority to deny OASI and DI benefits to fugitive felons who otherwise are eligible to receive them, and the Privacy Act authorizes but does not require SSA to provide information it collects about individuals, including OASI and DI recipients who are fugitive felons, to law enforcement agencies.

Social Security Reform: Potential Effects on SSA's Disability Programs and Beneficiaries (GAO-01-35, 24-JAN-01)

There has been little analysis of how the various Social Security reform proposals might affect the Social Security Disability Insurance (DI) program. This report assesses the potential impact of these proposals on the solvency of the DI trust fund and on the benefits disabled beneficiaries receive. GAO found that most disabled beneficiaries would receive higher benefits under the various Social Security reform proposals it reviewed than under a solvency scenario that maintained payroll tax rates while reducing benefits. However, most of the disabled beneficiaries GAO studied would receive lower benefits under three of the reform proposals reviewed than under a solvency scenario that maintained current-law benefits while raising payroll taxes. The proposals GAO studied treat DI beneficiaries similar

to Old-Age and Survivor Insurance beneficiaries. However, the circumstances facing disabled workers differ from those facing retired workers. The differences between disabled workers and retired workers suggest that Social Security reform proposals should be viewed not only in light of their effects on retired workers but also explicitly for their effect on disabled beneficiaries and their families.

Supplemental Security Income: Progress Made in Detecting and Recovering Overpayments, but Management Attention Should Continue (GAO-02-849, 16-SEP-02)

The Supplemental Security Income (SSI) program is the nation's largest cash assistance program for the poor. The program paid $33 billion in benefits to 6.8 million aged, blind, and disabled persons in fiscal year 2001. Benefit eligibility and payment amounts for the SSI population are determined by complex and often difficult to verify financial factors such as an individual's income, resource levels, and living arrangements. Thus, the SSI program tends to be difficult, labor intensive, and time consuming to administer. These factors make the SSI program vulnerable to overpayments. The Social Security Administration (SSA) has demonstrated a stronger commitment to SSI program integrity and taken many actions to better deter and detect overpayments. Specifically, SSA has (1) obtained legislative authority in 1999 to use additional tools to verify recipients' financial eligibility for benefits, including strengthening its ability to access individuals' bank account information; (2) developed additional measures to hold staff accountable for completing assigned SSI workloads and resolving overpayment issues; (3) provided field staff with direct access to state databases to facilitate more timely verification of recipient's wages and unemployment information; and (4) significantly increased, since 1998, the number of eligibility reviews conducted each year to verify recipient's income, resources, and continuing eligibility for benefits. In addition to better detection and deterrence of SSI overpayments, SSA has made recovery of overpaid benefits a high priority.

Sustained management attention should continue to ensure progress towards fully implementing crucial overpayment deterrence, detection, and recovery tools. Despite these efforts, further improvements in overpayment recovery are possible. The report includes recommendations that SSA address complex SSI program rules to better prevent payment errors, reassess its policies and procedures for imposing administrative penalties and sanctions, and ensure that overpayment waiver policies are designed and implemented in a way that maintains program integrity.

Welfare Reform: Implementation of Fugitive Felon Provisions Should Be Strengthened (GAO-02-716, 25-SEP-02)

In response to concerns that individuals wanted in connection with a felony or violating terms of their parole or probation could receive benefits from programs for the needy, Congress added provisions to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that prohibit these individuals from receiving Supplemental Security Income (SSI), Food Stamp benefits, and Temporary Assistance to Needy Families

(TANF) and make fugitive felon status grounds for the termination of tenancy in federal housing assistance programs. In addition, the Act directs these programs to provide law enforcement officers with information about program recipients for whom there are outstanding warrants to assist in their apprehension. Actions taken to implement the Act's fugitive felon provisions have varied substantially by program. In implementing provisions to prohibit benefits to fugitive felons, all but housing assistance programs include, at a minimum, a question about fugitive felon status in their applications. SSI and some state Food Stamp and TANF programs also seek independent verification of fugitive felon status by using computer matching to compare arrest warrant and program recipient files. To date, 110,000 beneficiaries have been identified as fugitive felons and dropped from the SSI, Food Stamp, and TANF rolls, and many have been apprehended. Computerized file matching has been responsible for the identification of most of these fugitive felons. Aggressive implementation of the Act's fugitive felon provisions poses a number of challenges for programs. First, centralized and complete national and statewide arrest warrant data for computer matching are not readily available. Second, because direct access to arrest warrants and criminal records is limited to law enforcement personnel, computer matching requires what many state TANF and Food Stamp officials view as a burdensome and complex negotiation process to obtain these records. Third, the absence of information and guidance about how to conduct file matching and overcome its logistical challenges has also hindered aggressive implementation of the law. Finally, there is evidence that individuals with outstanding warrants for felonies, or probation or parole violations, may continue to collect benefits because there may be differences in the interpretation of what constitutes a fugitive felon within the Food Stamp and TANF programs.

VETERANS/DOD ISSUES

DOD and VA Pharmacy: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs (GAO-01-588, 25-MAY-01)

The Department of Veterans Affairs (VA) and the Department of Defense (DOD) have made important progress, particularly during the past year, in their efforts to jointly procure drugs to help control spiraling prescription drug costs. Although their collaborative efforts have been impressive, the two agencies have largely targeted generic drugs, which comprise less than 10 percent of their combined expenditures. More dramatic cost reductions could be achieved through procurements of high-cost brand-name drugs, although doing so can be more complex and time consuming to garner the necessary clinical support and provider acceptance on therapeutic interchangeability. Nonetheless, DOD's greatly expanded retiree drug benefit and the formularies being developed by both agencies should provide added joint procurement opportunities for such drugs. Also, VA and DOD have shown that flexible approaches to developing joint solicitations can take into account differences in their health systems while still maximizing drug discounts. In GAO's view, their joint activities could be further enhanced by periodically conferring with private managed care pharmacy experts and reporting to Congress on their joint procurement activities. Top management at DOD and VA need to stay focused on their joint procurement and distribution activities as leadership changes continue at the two agencies. VA and DOD have also made progress in their efforts to conduct a consolidated mail outpatient pharmacy pilot. The sooner the pilot proves feasible, the sooner DOD can begin to realize the financial and quality of care benefits associated with the transfer of its refill workload.

Financial Management: Department of Defense Regulations Establishing Methods to Calculate Amounts To Be Transferred from Department of Defense Medicare Eligible Retiree Health Care Fund (GAO-02-1061R, 30-AUG-02)

GAO reviewed regulations issued by the Department of Defense (DOD) to cover transfers from a new fund created by Congress to finance the cost of expanded health care programs' benefits for Medicare-eligible uniformed services retirees and their eligible dependents. These health care programs include pharmacy benefits and coverage of the deductible portion of Medicare benefits. The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 established the Department of Defense Medicare Eligible Retiree Health Care Fund in the U.S. Treasury. Beginning on October 1, 2002, the fund will finance DOD's liabilities under the uniformed services retiree health programs for Medicare-eligible beneficiaries. The legislation requires that (1) the Secretary of Defense establish by regulation the methods for calculating amounts to be transferred periodically from the fund to applicable appropriations that incur the programs' cost and (2) the Comptroller General report to the Secretary of Defense and to Congress on the adequacy and appropriateness of these regulations within 30 days of receiving them from the Secretary. GAO found that regulations establishing the methods for calculating transfers from the fund to finance eligible health care costs were issued in July 2002, in sufficient time to begin making transfers upon activation of the fund on October 1, 2002. DOD regulations for establishing the methods for calculating transfers from the fund are adequate and appropriate, and they

provide a framework for the transfers to be implemented upon activation of the fund. Under these regulations, there are to be daily transfers from the fund to cover amounts disbursed to non-DOD providers, such as civilian health care providers and retail pharmacies, based on claims transactions. The regulations also provide the methodology for calculating transfers to cover the cost of military treatment facilities care to the intended beneficiaries. However, the reliability of the underlying cost and patient clinical data could limit DOD's ability to reliably assign costs and bill DOD for services to DOD Medicare-eligible retirees and their eligible dependents.

VA Drug Formulary: Better Oversight Is Required, but Veterans Are Getting Needed Drugs (GAO-01-183, 29-JAN-01)

During the last three years, the Department of Veterans Affairs (VA) has made significant progress in establishing its national drug formulary, which has generally met with prescriber acceptance. Most veterans are receiving the drugs they need. However, VA oversight has not been sufficient to ensure that the Veterans Integrated Service Networks (VISN) and medical centers comply with formulary policies and that the flexibility given to them does not compromise VA's goal of formulary standardization. Contrary to VA formulary policy, some facilities omitted national formulary drugs or modified the closed drug classes. Although a limited number of drugs to supplement the national formulary is permitted, formulary differences among facilities are likely to become more pronounced, as more drugs are added by VISNs, decreasing formulary standardization. VA recognizes the trade-off between local flexibility and standardization, but it lacks criteria for determining the appropriateness of adding drugs to supplement the national formulary and therefore may not be able to determine whether the decrease in standardization is acceptable.

VA Health Care: Allocation Changes Would Better Align Resources with Workload (GAO-02-338, 28-FEB-02)

The Department of Veterans Affairs (VA) spent $21 billion in fiscal year 2001 to treat 3.8 million veterans--most of whom had service-connected disabilities or low incomes. Since 1997, VA has used the Veterans Equitable Resource Allocation (VERA) system to allocate most of its medical care appropriation. GAO found that VERA has had a substantial impact on network resource allocations and workloads. First, VERA shifted $921 million from networks located primarily in the northeast and midwest to networks located in the south and west in fiscal year 2001. In addition, VERA, along with other VA initiatives, has provided an incentive for networks to serve more veterans. VERA's overall design is a reasonable approach to allocate resources commensurate with workloads. It provides a predetermined dollar amount per veteran served to each of VA's 22 health care networks. This amount varies depending upon the health care needs of the veteran served and local cost differences. This approach is designed to allocate resources commensurate with each network's workload in terms of veterans served and their health care needs. GAO identified weaknesses in VERA's implementation. First, VERA excludes about one fifth of VA's workload in determining each network's allocation. Second, VERA does not account well for cost differences among networks resulting from variation in their patients' health care needs. Third, the process for providing supplemental resources to networks through VA's National

Reserve Fund has not been used to analyze how the need for such resources is caused by potential problems in VERA's allocation, network inefficiency, or other factors.

VA Health Care: Expanded Eligibility Has Increased Outpatient Pharmacy Use and Expenditures (GAO-03-161, 08-NOV-02)

The Department of Veterans Affairs (VA) spent about $3.0 billion on its outpatient pharmacy benefit in fiscal year 2001. After VA implemented the Veterans' Health Care Eligibility Reform Act in 1999, more veterans could use VA outpatient care, including the pharmacy benefit, than before. Increased eligibility contributed to a doubling of the number of Priority 7 veterans using VA health care. Priority 7 veterans are primarily veterans with higher incomes and no service-connected disability. GAO was asked to report on Priority 7 veterans' use of the outpatient pharmacy benefit and VA's expenditures to provide this benefit. To do this, GAO reviewed VA pharmacy data on use and costs from fiscal years 1999 through 2001.

VA spent $418 million on the outpatient pharmacy benefit for Priority 7 veterans in fiscal year 2001. VA pharmacy expenditures for Priority 7 veterans in this year were offset by copayments for drugs. In fiscal year 2001, VA collected approximately $41 million in drug copayments from Priority 7 veterans by charging $2 for a 30-day or less supply. This reduced VA's net expenditures to $377 million. After VA implemented eligibility reform in 1999, Priority 7 veterans' use of the pharmacy benefit increased rapidly from about 11 million 30-day equivalents of drugs or supplies in fiscal year 1999 to about 26 million 30-day equivalents in fiscal year 2001. This resulted in more than a doubling of VA's net pharmacy expenditures for these veterans. Yet, net pharmacy expenditures for Priority 7 veterans remain a relatively small share of VA's total net spending for outpatient drugs and supplies. Most of VA's increased pharmacy spending during this period was for all other veterans--those with service-connected disabilities, low incomes, or certain other recognized statuses such as former prisoners of war. In fiscal year 2001, 87 percent of VA's net pharmacy expenditures were for these veterans.

VA Health Care: Implementation of Prescribing Guideline for Atypical Antipsychotic Drugs Generally Sound (GAO-02-579, 29-APR-02)

The Department of Veterans Affairs (VA) provides health care services to veterans who have been diagnosed with psychosis--primarily schizophrenia, a disorder that can substantially limit their ability to care for themselves, secure employment, and maintain relationships. These veterans also have a high risk of premature death, including suicide. Effective treatment, especially antipsychotic drug therapy, has reduced the severity of their illnesses and increased their ability to function in society. VA's guideline for prescribing atypical antipsychotic drugs is sound and consistent with published clinical practice guidelines used by public and private health care systems. VA's prescribing guideline recommends that physicians use their best clinical judgment, based on clinical circumstances and patients' needs, when choosing among the atypical drugs. Most Veterans Integrated Service Networks (VISN) and facilities use VA's prescribing guideline; however, five VISNs have additional policies and procedures for prescribing atypical antipsychotic drugs. Although these

procedures help manage pharmaceutical cost, they also have the potential to result in more weight given to cost than clinical judgment, which is inconsistent with the prescribing guideline.

VA Health Care: More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress (GAO-01-953, 31-AUG-01)

In fiscal year 2000, roughly four million patients made 39 million outpatient visits to more than 700 health care facilities nationwide, run by the Department of Veterans Affairs (VA). However, excessive waiting times for outpatient care have been a long-standing problem. To ensure timely access to care, VA established a goal that all nonurgent primary and specialty care appointments be scheduled within 30 days; clinics were to meet this goal by 1998. Yet, three years later, reports of long waiting times persist. Waiting times at the clinics in the 10 medical centers GAO visited indicate that meeting VA's 30-day standard is a continuing challenge for many clinics. Although most of the primary care clinics GAO visited (15 of 17) reported meeting VA's standard for nonurgent, outpatient appointments, only one-third of the specialty care clinics visited (18 of 54) met VA's 30-day standard. For the remaining two-thirds, waiting times ranged from 33 days at one urology clinic to 282 days at an optometry clinic. Although two-thirds of the specialty clinics GAO visited continued to have long waiting times, some were making progress in reducing waiting times, primarily by improving their scheduling processes and making better use of their staff. These successes were often the result of collaborative efforts with the Institute for Healthcare Improvement (IHI) a private contractor VA retained in July 1999—to develop strategies to reduce patient waiting times. Medical centers and clinics participating in VA's IHI project have received valuable information and strategies for successfully reducing waiting times. However, VA has only recently contracted with IHI to disseminate best practices agency-wide and VA has not established a national set of referral guidelines that could alleviate waiting times for specialty care.

VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services Is Uneven (GAO-02-510R, 29-MAR-02)

The Department of Veterans Affairs (VA) spent about $3.1 billion on long-term care in fiscal year 2001. This amount is likely to increase as the veteran population ages. VA provides or pays for long-term care in institutional settings, such as nursing homes, or in veteran's own homes and other community locations. The Veterans Millennium Health Care and Benefits Act of 1999 required VA to offer long-term care services to eligible veterans, including in noninstitutional settings. More than two years after the act's passage, VA has not completely met the act's requirement that all eligible veterans be offered adult day health care, respite care, and geriatric evaluation. Although VA published draft regulations that would make these three services available, the regulations were not finalized as of March 2002. To respond to the act's requirements before its draft regulations were finalized, VA issued a policy directive making these three services available in noninstitutional settings. At the time of GAO's review, however, access to these services was far from universal. Moreover, the availability of all VA noninstitutional long-term care services, including the newly required services, is uneven across the VA system.

VA Long-Term Care: Oversight of Community Nursing Homes Needs Strengthening (GAO-01-768, 27-JUL-01)

The Department of Veterans Affairs (VA) spent about $1.9 billion—or about 10 percent of its health care budget—to provide nursing home care to veterans in fiscal year 2000. VA will likely see increasing demand for nursing home care during the next decade. The number of veterans age 85 and older is expected to triple—from 422,000 veterans in 2000 to nearly 1.3 million in 2010. Among the very old, the prevalence of chronic health conditions and disabilities increases markedly. In addition, VA is required to provide long-term care to some veterans, which may further increase veterans' demand for nursing home care. Almost 73 percent of VA's nursing home care in fiscal year 2000 went to VA's 134 nursing homes; the rest went to state-owned and operated veterans' nursing homes (15 percent) or to community nursing homes under local or national contract to VA (12 percent). VA generally requires its medical center staff to conduct annual inspections of state veterans' homes and community nursing homes; it also requires monthly staff visits to veterans in community nursing homes. GAO found that VA's adherence to its oversight policies for state veterans' homes and community nursing homes has been mixed because of a lack of VA monitoring and oversight. VA medical staff are required to inspect each state veterans' home annually, and of the 86 inspections reviewed by GAO, about 85 percent were done within the time frame or shortly thereafter. VA lacks a departmentwide approach to monitoring medical centers' community nursing home oversight activities and enforcing VA's oversight policies--particularly regarding locally contracted homes, which make up about 75 percent of the community nursing homes under contract to VA—and individual medical centers vary in how well they have overseen community nursing homes. Under its planned policy change, VA would eliminate the requirement for annual inspections of community nursing homes and instead would rely on Medicare and Medicaid certification inspections. Local VA medical centers' staff will review state inspection reports and CMS data to evaluate community nursing homes. However, the quality of state inspections of nursing homes varies, and CMS is unable to accurately assess state inspection results in all cases.

Medicare Subvention Demonstration: DOD Costs and Medicare Spending (GAO-02-67, 31-OCT-01)

The Balanced Budget Act of 1997 authorized the Department of Defense (DOD) to conduct the Medicare subvention demonstration for a three-year period. Under this demonstration, DOD formed Medicare managed care organizations—collectively called TRICARE Senior Prime—at six sites that provided the full range of Medicare-covered services as well as additional DOD-covered services, notably prescription drugs. The Medicare program was to pay DOD for Medicare-covered care of the enrolled military retirees if DOD continued to spend on all aged military retirees at least as much as it had historically. Under the subvention demonstration, Senior Prime enrollees' care in 1999 cost DOD far more than the Medicare capitation rate that was established for the demonstration. This mainly resulted from enrollees' heavy use of medical services, but DOD coverage of prescription drugs—not included in the Medicare benefit package—also contributed to its high costs. Without the demonstration, Medicare spending in 1999 for retirees who enrolled in Senior Prime would

have been, on average, about 55 percent of the Senior Prime capitation rate. This was partly because Senior Prime enrollees were somewhat healthier than comparable Medicare beneficiaries, but mainly because Medicare would have paid for only part of the enrollees' care. DOD would have provided much of their care, which would not have been reflected in Medicare's spending on their behalf. The Balanced Budget Act's payment rules resulted in no Medicare payment to DOD in 1999. This was because they were designed to prevent the government from paying twice for the same care—once through DOD appropriations and again through Medicare. The rules also required that the payment be adjusted to account for Senior Prime enrollees' health status. Together, these two requirements resulted in Medicare paying nothing for care provided in 1999. Even without these two requirements, Medicare would have paid DOD less than the monthly capitation rate of $320 per person, because Congress had capped the Medicare payment for all enrollees at $60 million for 1999.

Medicare Subvention Demonstration: DOD's Pilot HMO Appealed to Seniors, Underscored Management Complexities (GAO-01-671, 14-JUN-01)

This interim report reviews the implementation of the Department of Defense (DOD) Medicare Subvention Demonstration. GAO found that the demonstration sites were successful in operating Medicare managed care plans. Officials put substantial effort into meeting Medicare managed care requirements and, according to Health Care Financing Administration reviewers, were generally as successful as other new Medicare managed care plans in this regard. Most sites reached the enrollment limits they had established for retirees already covered by Medicare. DOD officials indicated that the demonstration's effect was positive. Enrollees received a broader range of services from DOD than in the past, when they got care only when space was available in DOD facilities. Officials also noted that providing more comprehensive care to seniors helped sharpen the skills of military clinical staff, which contributed to their readiness for supporting combat or other military missions. Some challenges encountered in the demonstration reflect larger DOD managed care issues and may have implications for DOD managed care generally. Although access to care was generally good, the demonstration experienced some problems in maintaining adequate clinical staff.

Medicare Subvention Demonstration: Greater Access Improved Enrollee Satisfaction but Raised DOD Costs (GAO-02-68, 31-OCT-01)

In the Balanced Budget Act of 1997, Congress established a three-year demonstration, called Medicare subvention, to improve the access of Medicare-eligible military retirees to care at military treatment facilities (MTF). The demonstration allowed Medicare-eligible retirees to get their health care largely at MTFs by enrolling in a Department of Defense (DOD) Medicare managed care organization known as TRICARE Senior Prime. During the subvention demonstration, access to health care for many retirees who enrolled in Senior Prime improved, while access to MTF care for some of those who did not enroll declined. Many enrollees in Senior Prime said they were better able to get care when they needed it. They also reported better access to doctors in general as well as to care at MTFs. Enrollees generally were more satisfied with their care than before the demonstration. However, the demonstration did not improve enrollees' self-reported health status. In addition, compared to nonenrollees, enrollees did not have better health outcomes, as measured by their mortality rates and rates of "preventable" hospitalizations. Moreover, DOD's costs were high, reflecting enrollees' heavy use of hospitals and doctors.

Medicare Subvention Demonstration: Pilot Satisfies Enrollees, Raises Cost and Management Issues for DOD Health Care (GAO-02-284, 11-FEB-02)

The Department of Defense's (DOD) Medicare subvention demonstration tested alternate approaches to health care coverage for military retirees. Retirees could enroll in new DOD-run Medicare managed care plans, known as TRICARE Senior Prime, at six sites. The demonstration plan offered enrollees the full range of Medicare-covered services as well as additional TRICARE services, with minimal copayments. During the demonstration period, the program parameters were changed, allowing military retirees age 65 and older to become eligible for TRICARE coverage as of October 1, 2001, and Senior Prime was extended for one year. The demonstration showed that retirees were interested in enrolling in low-cost military health plans and that DOD was able to satisfy its Senior Prime enrollees. By the close of the initial demonstration period, about 33,000 retirees were enrolled in Senior Prime, and more were on waiting lists. When nonenrollees were asked why they did not join Senior Prime, more than 60 percent said that they were satisfied with their existing health coverage; few said that they disliked military care. Although the demonstration had positive results for enrollees, it also highlighted three challenges confronting the military health system in managing patient care and costs. First, care needs to be managed more efficiently. Although DOD satisfied enrollees and gave them good access to care, it incurred high costs. Second, DOD's efforts were hindered by limitations in its data and data systems. Finally, the demonstration illustrated the tension between the military health system's commitment to support military operations and promote the health of active-duty personnel and its commitment to provide care to dependents of active-duty personnel, retirees and their families, and survivors.

OTHER ISSUES

Electronic Transfers: Use by Federal Payment Recipients Has Increased but Obstacles to Greater Participation Remain (GAO-02-913, 12-SEP-02)

In 2001, the Department of the Treasury made 764 million payments valued at $549 billion to beneficiaries of federal programs, primarily programs administered by the Social Security Administration. Of these payments, 76 percent were made using electronic funds transfers (EFTs), potentially saving the government millions of dollars in costs associated with disbursing paper checks. In 1996, Congress passed legislation, which required that federal payments except tax refunds be made electronically as of January 1999. The act also required that each person affected by this mandate have access to an account at a financial institution at a reasonable cost and with certain consumer protections. To meet this requirement, Treasury developed the Electronic Transfer Account (ETA). Most recipients of federal benefits have their payments deposited electronically. The number of recipients using EFT climbed steadily throughout the 1990s, rising from around half to more than three-quarters of all beneficiaries. Treasury and the Social Security Administration (SSA) have undertaken activities to increase the use of direct deposit, including developing marketing material and directly notifying check recipients of the advantages of using EFT, particularly safety and convenience. Although information describing the characteristics of these EFT users is limited, GAO determined that participation rates are highest for those 65 and older. The primary obstacle to using EFT was that many federal check recipients did not have a bank account. GAO's analysis of the Survey of Income and Program Participation's 1998 data indicated that 11 million benefit recipients, over half of all federal benefit check recipients in 1998, were unbanked. The ETA has not been widely accepted by banks or unbanked beneficiaries despite Treasury's efforts to promote it. Since initiation of the program in 1999, 36,000 ETAs have been opened, representing fewer than 1 percent of unbanked beneficiaries. Based on discussions with representatives from Treasury, SSA, financial institutions, and consumer groups, GAO identified several approaches that Treasury could consider to increase the use of electronic transfers. These approaches include increasing cooperation between banks and local SSA offices to more effectively enroll beneficiaries for ETAs; exploring other electronic payment options besides the ETA to deliver benefits; partnering with banks to provide information on the general availability of low cost banking products, especially in areas with low ETA coverage; and conducting further research to determine why certain states have low direct deposit participation rates.

Information Technology Management: Social Security Administration Practices Can Be Improved (GAO-01-961, 21-AUG-02)

The Social Security Administration (SSA) needs to identify strengths and weaknesses within its agency-wide operational and managerial capabilities to enable the delivery of high-quality customer service in the face of increases in both workloads and in the number of retirements from its experienced workforce. Evaluating SSA's management of information technology (IT) is critical to assess whether the agency is adequately addressing these capabilities. This report reviews SSA's IT policies, procedures, and practices in the following five areas: investment management, enterprise architecture, software acquisition and development, information security, and human capital. GAO found that SSA had many important IT management policies and procedures in place in each of these five key areas but did not

always implement them consistently. In some areas, SSA had not established key policies, procedures, or practices essential to ensure that its IT was effectively managed. GAO found weaknesses in all of the five key areas of IT management—particularly in investment management and human capital management.

Record Linkage and Privacy: Issues in Creating New Federal Research and Statistical Information (GAO-01-126SP, 01-APR-01)

This study focuses on privacy issues related to record-linkage—a computer-based process that combines multiple of existing data on individual persons. Federally sponsored linkage projects conducted for research and statistical purposes have many potential benefits, such as informing policy debates; tracking program outcomes; or contributing knowledge that, in some cases, might benefit millions of people. Examples of record linkage in GAO's study include the use of administrative and survey data on the aging to provide a better understanding of health care and income security issues relevant to this population. Despite these benefits, concerns about personal privacy are relevant because linkages often involve data on identifiable persons. GAO describes (1) how record linkage can create new research and statistical information related to the aging and other populations, (2) why linkage heightens certain privacy issues, and (3) how data stewardship might be enhanced.

Testimonies: Calendar Years 2001 and 2002, Issues Affecting Older Americans

HEALTH ISSUES

Flu Vaccine: Steps Are Needed to Better Prepare for Possible Future Shortages (GAO-01-786T, 30-MAY-01)

Until the 2001 flu season, the production and distribution of influenza vaccine generally went smoothly. Last year, however, several people reported that they wanted but could not get flu shots. In addition, physicians and public health departments could not provide shots to high-risk patients in their medical offices and clinics because they had not received vaccine they ordered many months in advance, or because they were being asked to pay much higher prices for vaccine in order to get it right away. At the same time, there were reports that providers in other locations, even grocery stores and restaurants, were offering flu shots to everyone--including younger, healthier people who were not at high risk. This testimony discusses the delays in production, distribution, and pricing of the 2000-2001 flu vaccine. GAO found that manufacturing difficulties during the 2000-2001 flu season resulted in an overall delay of about six to eight weeks in shipping vaccine to most customers. This delay created an initial shortage and temporary price spikes. There is no system in place to ensure that high-risk people have priority for receiving flu shots when supply is short. Because vaccine purchases are mainly done in the private sector, federal actions to help mitigate any adverse effects of vaccine delays or shortages need to rely to a great extent on collaboration between the public and private sectors.

Health Insurance: Proposals for Expanding Private and Public Coverage (GAO-01-481T, 15-MAR-01)

Various approaches have been proposed to increase private and public health care coverage of uninsured persons. The success of these proposals will depend on several key factors. The impact of tax subsidies on promoting private health insurance will depend on whether the subsidies reduce premiums enough to induce uninsured low-income individuals to buy health insurance and on whether these subsidies can be made available at the time the person needs to pay premiums. The effectiveness of public program expansions will depend on states' ability and willingness to use any new flexibility to cover uninsured residents as well as develop effective outreach to enroll the targeted populations. Although crowd-out is a concern with any of the approaches, some degree of public funds going to those currently with private health insurance may be inevitable to provide stable health coverage for some of the 42 million uninsured Americans.

Health Products for Seniors: Potential Harm From 'Anti-Aging' Products (GAO-01-1139T, 10-SEP-01)

Dietary supplements marketed as anti-aging therapies may pose a potential for physical harm to senior citizens. Evidence from the medical literature shows that a variety of frequently used dietary supplements can have serious health consequences for seniors. Particularly risky are products that may be used by seniors who have underlying diseases or health conditions that make the use of the product medically inadvisable or supplements that interact with medications that are being taken concurrently. Studies have also found that these products sometimes contain harmful contaminants or much more of an active ingredient than is indicated on the label. Although GAO was unable to find any recent, reliable estimates of the overall economic harm to seniors from these products, it did uncover several examples that illustrate the risk of economic harm. The Food and Drug Administration (FDA) and the Federal Trade Commission (FTC) have identified several products that make advertising or labeling claims with insufficient substantiation, some costing consumers hundreds or thousands of dollars apiece. The potential for harm to senior citizens from health products making questionable claims has been a concern for public health and law enforcement officials. FDA and FTC sponsor programs and provide educational materials for senior citizens to help them avoid health fraud. At the state level, agencies are working to protect consumers of health products by enforcing state consumer protection and public health laws, although anti-aging and alternative products are receiving limited attention. This testimony summarized a September report (GAO-01-1129).

Health Workforce: Ensuring Adequate Supply and Distribution Remains Challenging (GAO-01-1042T, 01-AUG-01)

This testimony discusses (1) the shortage of healthcare workers and (2) the lessons learned by the National Health Service Corps (NHSC) in addressing these shortages. GAO found that problems in recruiting and retaining health care professionals could worsen as demand for these workers increases. High levels of job dissatisfaction among nurses and nurses aides may also play a crucial role in current and future nursing shortages. Efforts to improve the workplace environment may both reduce the likelihood of nurses and nurse aides leaving the field and encourage more young people to enter the nursing profession. Nonetheless, demographic forces will continue to widen the gap between the number of people needing care and the nursing staff available. As a result, the nation will face a caregiver shortage very different from shortages of the past. More detailed data are needed, however, to delineate the extent and nature of nurse and nurse aide shortages to assist in planning and targeting corrective efforts. Better coordination of NHSC placements, with waivers for foreign U.S.-educated physicians, could help more needy areas. In addition, addressing shortfalls in the Department of Health and Human Services (HHS) systems for identifying underservice is long overdue. HHS needs to gather more consistent and reliable information on the changing needs for services in underserved communities. Until then, it will remain difficult to determine whether federal resources are appropriately targeted to communities of greatest need and to measure their impact.

Long-Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets (GAO-02-544T, 21-MAR-02)

As more and more of the baby boomers enter retirement age, spending for Medicare, Medicaid, and Social Security is expected to absorb correspondingly larger shares of federal revenue and threatens to crowd out other spending. The aging of the baby boomers will also increase the demand for long-term care and contribute to federal and state budget burdens. The number of disabled elderly who cannot perform daily living activities without assistance may double in the future. Long-term care spending from public and private sources--about $137 billion for persons of all ages in 2000--will rise dramatically as the baby boomers age. Without fundamental financing changes, Medicaid--which pays more than one-third of long-term care expenditures for the elderly--can be expected to remain one of the largest funding sources, straining both federal and state governments.

Long-Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services (GAO-01-563T, 27-MAR-01)

The confluence of the aging baby boom generation, longer life expectancies, and evolving options for providing and financing long-term care services will require substantial public and private investment in long-term care and the development of sufficient capacity to serve this growing population. Spending for long-term care was about $134 billion in 1999. Medicaid and Medicare paid for nearly 58 percent of these services, contributing about $59 billion and $18 billion, respectively. Private long-term care insurance is viewed as a possible way to reduce catastrophic financial risk for the elderly needing long-term care and to relieve some of the financing burden now shouldered by public long-term care programs. Yet private insurance represents only about 10 percent of long-term care spending. Questions remain about the affordability of policies and the value of the coverage relative to the premiums charged. Although many states have adopted standards for long-term care policies, it is uncertain whether these standards have bolstered consumer confidence in the reliability of long-term care insurance. If long-term care insurance is to have a more significant role in addressing the baby boom generation's upcoming chronic health care needs, consumers must view the policies being offered as reliable, affordable products with benefits and limitations that are easy to understand.

Long-Term Care: Elderly Individuals Could Find Significant Variation in the Availability of Medicaid Home and Community Services (GAO-02-1131T, 26-SEP-02)

As the baby boomers age, spending on long-term care for the elderly could nearly quadruple by 2050. The growing demand for long-term care will put pressure on federal and state budgets because long-term care relies heavily on public financing, particularly Medicaid. Nursing home care traditionally has accounted for most Medicaid long-term care expenditures, but the high costs of such care and the preference of many individuals to stay in their own homes has led states to expand their Medicaid programs to provide coverage for home- and community-based long-term care. GAO found that a Medicaid-eligible elderly individual with the same disabling conditions, care needs, and availability of informal family support could find significant differences in the type and intensity of home and community-

based services that would be offered for his or her care. These differences were due in part to the very nature of long-term care needs--which can involve physical or cognitive disabling conditions--and the lack of a consensus as to what services are needed to compensate for these disabilities and what balance should exist between publicly available and family-provided services. The differences in care plans were also due to decisions that states have made in designing their Medicaid long-term care programs and the resources devoted to them. The case managers GAO contacted generally offered care plans that relied on in-home services rather than other residential care settings. However, the extent of in-home services offered varied considerably.

Long-Term Care: Implications of Supreme Court's Olmstead Decision Are Still Unfolding (GAO-01-1167T, 24-SEP-01)

In the Olmstead case, the Supreme Court decided that states were violating title II of the Americans with Disabilities Act of 1990 (ADA) if they provided care to disabled people in institutional settings when they could be appropriately served in a home or community-based setting. Considerable attention has focused on the decision's implications for Medicaid, the dominant public program supporting long-term care institutional, home, and community-based services. Although Medicaid spending for home and community-based service is growing, these are largely optional benefits that states may or may not choose to offer, and states vary widely in the degree to which they cover them. The implications of the Olmstead decision--in terms of the scope and the nature of states' obligation to provide home and community-based long-term care services--are still unfolding. Although the Supreme Court ruled that providing care in institutional settings may violate the ADA, it also recognized that there are limits to what states can do, given the available resources and the obligation to provide a range of services for disabled people. The decision left many open questions for states and lower courts to resolve. State programs also may be influenced over time as dozens of lawsuits and hundreds of formal complaints seeking access to appropriate services are resolved.

Medicare: Cost Sharing Policies Problematic for Beneficiaries and Program (GAO-01-713T, 09-MAY-01)

Medicare provides valuable and extensive health care coverage for beneficiaries. Nevertheless, significant gaps leave some beneficiaries vulnerable to sizeable financial burdens from out-of-pocket expenses. Medigap is a widely available source of supplemental coverage. This testimony discusses (1) beneficiaries' potential financial liability under Medicare's current benefit structure and cost-sharing requirements, (2) the cost of Medigap policies and the extent to which they provide additional coverage, and (3) concerns that Medigap's so-called "first dollar" coverage undermines the cost control incentives of Medicare's cost-sharing requirements. GAO found that Medicare's benefits package and cost-sharing requirements leave beneficiaries liable for high out-of-pocket costs. Medigap policies pay for some or all Medicare cost-sharing requirements but do not fully protect beneficiaries from potentially significant out-of-pocket costs such as prescription drug coverage. Medigap first-dollar coverage eliminates the ability of Medicare's cost-sharing requirements to promote prudent use of services.

Medicare: Financial Outlook Poses Challenges for Sustaining Program and Adding Drug Coverage (GAO-02-643T, 17-APR-02)

The lack of outpatient prescription drug coverage may leave Medicare's most vulnerable beneficiaries with high out-of-pocket costs. Recent estimates suggest that, at any given time, more than a third of Medicare beneficiaries lack prescription drug coverage. The rest have some coverage through various sources--most commonly employer-sponsored health plans. Recent evidence indicates that this coverage is beginning to erode. The short- and long-term cost pressures facing Medicare will require substantial financing and programmatic reforms to put future Medicare on a sustainable footing. In the absence of a drug benefit, many Medicare beneficiaries obtain coverage through health plans, public programs, and the Medigap insurance market. The price, availability, and level of such coverage varies widely, leaving substantial gaps and exposure to high out-of-pocket costs for thousands. Despite pressures to adopt a prescription drug benefit, the rapidly rising cost of current obligations argues for careful deliberation and extreme caution in expanding benefits. GAO's long-term simulations show that the aging of the baby boomers and rising per capita health care spending will, absent meaningful reform, lead to massive fiscal challenges in future years.

Medicare: New Spending Estimates Underscore Need for Reform (GAO-01-1010T, 25-JUL-01)

Although the short-term outlook of Medicare's hospital insurance trust fund improved in the last year, Medicare's long-term prospects have worsened. The Medicare Trustee's latest projections, released in March, use more realistic assumptions about health care spending in the years ahead. These latest projections call into question the program's long-term financial health. The Congressional Budget Office also increased its long-term estimates of Medicare spending. The slowdown in Medicare spending growth in recent years appears to have ended. In the first eight months of fiscal year 2001, Medicare spending was 7.5 percent higher than a year earlier. This testimony discusses several fundamental challenges to Medicare reform. Without meaningful entitlement reform, GAO's long-term budget simulations show that an aging population and rising health care spending will eventually drive the country back into deficit and debt. The addition of a prescription drug benefits would boost spending projections even further. Properly structured reform to promote competition among health plans could make Medicare beneficiaries more cost conscious. The continued importance of traditional Medicare underscores the need to base adjustments to provider payments on hard evidence rather than on anecdotal information. Similarly, reforms in the management of the Medicare program should ensure that adequate resources accompany increased expectations about performance and accountability. Ultimately, broader health care reforms will be needed to balance health care spending with other societal priorities.

Medicare: Use of Preventive Services is Growing but Varies Widely (GAO-02-777T, 23 - MAY-02)

Preventive health care services can extend lives and promote the well being of the nation's seniors. Medicare now covers 10 preventive services—three types of immunizations and

seven types of screenings—and legislation has been introduced to cover additional services. However, not all beneficiaries avail themselves of Medicare's preventive services. Some may simply choose not to use them, but others may be unaware that these services are covered by Medicare. Although the use of Medicare preventive service is growing, it varies from service to service and by state, ethnic group, income, and level of education. To ensure that preventive services are delivered to those who need them, the Centers for Medicare and Medicaid Services (CMS) sponsors activities to increase their use. CMS now funds interventions to increase the use of three services—breast cancer screening and immunizations against the flu and pneumonia--in each state. CMS also pays for interventions to increase use of services by minorities and low-income beneficiaries with low usage rates. CMS is evaluating the effectiveness of current efforts and expects to have the evaluation results later in 2002.

Medicare Hospital and Physician Payments: Geographic Cost Adjustments Important to Preserve Beneficiary Access to Services (GAO-02-968T, 23-JUL-02)

This testimony discusses Medicare program payment adjustments to hospitals and physicians that account for geographic differences in costs. Because Medicare's hospital and physician payment systems are based on national rates, these geographic cost adjustments are essential to account for costs beyond providers' control and to ensure that beneficiaries have adequate access to services. If these adjustments are not adequate, this could affect providers' financial stability and their ability or willingness to continue serving Medicare patients. Medicare's payments to hospitals vary with the average wages paid in a hospital's labor market. Yet, some hospitals believe that the labor cost adjustment applied does not reflect the average wage in their labor market area. Medicare's labor cost adjustment does not adequately account for geographic differences in hospital wages in some areas because a single adjustment is applied to all hospitals in an area, even though it may encompass multiple labor markets or different types of communities within which hospitals pay significantly different average wages. Geographic reclassification addresses some inequities in Medicare's labor cost adjustments by allowing some hospitals that pay wages enough above the average in their area to receive higher labor cost adjustments. However, some hospitals can reclassify even though they pay wages that are comparable to the average in their area. To help ensure that beneficiaries in all parts of the country have access to services, Medicare adjusts its physician fee schedule on the basis of indexes designed to reflect cost differences among 92 geographic areas. The adjustment is designed to help ensure that the fees paid appropriately reflect the cost of living and operating a practice in that area.

Medicare Management: Current and Future Challenges (GAO-01-878T, 19-JUN-01)

Medicare is a popular program that millions of Americans depend on for covering their essential health needs. However, the management of the program has fallen short of expectations because it has not always appropriately balanced or satisfied the needs of beneficiaries, providers, and taxpayers. For example, stakeholders expect that Medicare will price services prudently; that providers will be treated fairly and paid accurately; and that beneficiaries will clearly understand their program options and will receive services that meet quality standards. In addition, there are expectations that the agency will be prepared to

implement restructuring or added benefits in the context of Medicare reform. Today's Medicare, although successful in some areas, may not be able to meet these expectations effectively without further congressional attention to its multiple missions, capacity, and flexibility. The program will also need to do its part by implementing a performance-based approach that articulates priorities, documents resource needs, and holds managers accountable for accomplishing program goals.

Medicare Outpatient Drugs: Program Payments Should Better Reflect Market Prices (GAO-02-531T, 14-MAR-02)

In some cases, Medicare pays significantly more for covered outpatient drugs than the actual costs to the physicians and pharmacy suppliers. Attempts to reduce these payments have been met with provider claims that overpayments for the drugs are needed to cover underpayments for administering or delivering them. Medicare's method for establishing drug payments is flawed. Medicare pays 95 percent of the average wholesale price (AWP), which, despite its name, is neither an average nor a price that wholesalers charge. Instead, it is a number that manufacturers derive using their own criteria. There are no requirements or conventions that AWP reflect the price of actual drug sales. Widely available prices for drugs in 2001 were substantially below AWP. For both physician-billed drugs and pharmacy supplier-billed drugs, Medicare payments often far exceeded widely available prices. Physicians and pharmacy suppliers contend that the excess payments for covered drugs are necessary to offset what they claim are inappropriately low Medicare payments or no such payments for services related to the administration or delivery of these drugs. Although physicians receive an explicit payment for administering drugs, Medicare's payment policies for delivering pharmacy supplier-billed drugs and related equipment are uneven. Pharmacy suppliers billing Medicare receive a dispensing fee for one drug type--inhalation therapy drugs--but not for other covered drugs, such as infusion therapy or covered oral drugs. Other payers and purchasers, such as private health plans and the Department of Veterans Affairs (VA), use different approaches to pay for or buy drugs that may be instructive for Medicare. In particular, VA uses the leverage from the volume of federal drug purchases to secure verifiable data on actual market transactions, and it uses the prices paid by manufacturers' best customers to set Federal Supply Schedule prices.

Medicare Physician Payments: Spending Targets Encourage Fiscal Discipline, Modifications Could Stabilize Fees (GAO-02-441T, 14-FEB-02)

Congress implemented a physician fee schedule and a fee update formula to moderate spending growth relative to specified Medicare spending targets. These spending targets increase annually to reflect higher costs for physician services, the growth in the overall economy, and changes in the number of Medicare beneficiaries. Physician fees are adjusted for changes in the costs of providing services and on actual cumulative spending compared to the cumulative targets. The annual update may increase or decrease fees depending on whether actual spending fell below or exceeded the targets. In November 2001, the Centers for Medicare and Medicaid announced that Medicare's fees would decline 5.4 percent from what was paid in 2001, despite an estimated 2.6 percent increase in the cost of physician inputs. This reduction occurred because historical cumulative spending exceeded the target by $8.9 billion, or 13 percent of estimated 2002 spending. Several factors contributed to the

disparity between actual and targeted spending, including the correction of substantial errors in past spending estimates and the revision of targets for prior years. The current update mechanism could be modified to moderate fluctuations in physician fees and to ensure adequate payments, while retaining the fiscal discipline created by a spending target. Such modifications would need to balance concerns about preserving fiscal discipline on physician spending with the need to maintain adequate payment rates to ensure that beneficiaries have access to physician services. Because the paramount consideration in setting payment rates is ensuring appropriate beneficiary access to services, timely and detailed data on Medicare beneficiary service use are essential to achieving this balance.

Medicare Reform: Modernization Requires Comprehensive Program View (GAO-01-862T, 14-JUN-01)

Medicare faces many challenges. The overarching issue is how to sustain the program for future generations. Meeting that challenge will require difficult decisions that will affect beneficiaries, providers, and taxpayers. However, the financing issue should not obscure other important challenges. Medicare's current cost-sharing arrangements do not encourage the efficient use of services without discouraging necessary care. Moreover, the lack of catastrophic coverage can leave some beneficiaries liable for substantial Medicare expenses. Finally, some aspects of Medicare's program management are inefficient and lag behind modern private sector practices. Changes in Medicare's program management could improve both the delivery of health care to beneficiaries and the program's ability to pay providers appropriately. Some view restructuring of the relationship between parts A and B as an important element of overall Medicare reform. Fundamentally, assessing the program as a whole is an important first step in addressing Medicare's challenges. Solutions to many of these challenges could be crafted without restructuring. However, restructuring may provide opportunities to implement desired reforms--with or without unifying the Hospital Insurance and Supplemental Medical Insurance trust funds--while undoubtedly raising issues that will have to be considered.

Medigap: Current Polices Contain Coverage Gaps, Undermine Cost Control Incentives (GAO-02-533T, 14-MAR-02)

Medicare provides valuable and extensive health care coverage for 40 million elderly and disabled beneficiaries. Nevertheless, significant gaps leave some beneficiaries vulnerable to sizeable out-of-pocket expenses. Medicare provides no limit on out-of-pocket spending and no coverage for most outpatient prescription drugs. Most beneficiaries have supplemental coverage that helps to fill Medicare coverage gaps and pay some out-of-pocket expenses. Privately purchased Medigap policies are a widely available source of supplemental coverage. The other sources—employer-sponsored policies, Medicare + Choice plans, and Medicaid—are not available to all beneficiaries. Medigap policies help to fill in some of Medicare's gaps but also have shortcomings. In 1999, premiums paid for Medigap policies averaged $1,300, with more than 20 percent going to administrative costs. Medigap plans typically cover Medicare's required deductibles, coinsurance, and copayments but do not fully protect beneficiaries from potentially significant out-of-pocket costs. Medigap policies

offering prescription drug coverage can be inadequate because beneficiaries still pay most of the cost and the Medigap benefit is capped.

Nursing Homes: Many Shortcomings Exist in Efforts to Protect Residents from Abuse (GAO-02-448T, 04-MAR-02)

Often suffering from multiple physical and mental impairments, the 1.5 million elderly and disabled Americans living in nursing homes are a highly vulnerable population. These individuals typically require extensive help with daily living, such as such as dressing, feeding, and bathing. Many require skilled nursing or rehabilitative care. In recent years, reports of inadequate care, including malnutrition, dehydration, and other forms of neglect, have led to mounting scrutiny from state and federal authorities. Concerns have also been growing that some residents are abused--pushed, slapped, or beaten--by the very individuals to whom their care has been entrusted. GAO found that allegations of physical and sexual abuse of nursing home residents are not reported promptly. Local law enforcement officials said that they are seldom summoned to nursing homes to immediately investigate allegations of abuse and that few allegations are ever prosecuted. Some agencies use different policies when deciding whether to refer allegations of abuse to law enforcement. As a result, law enforcement agencies were never told of some incidents or were notified only after lengthy delays. GAO found that federal and state safeguards intended to protect nursing home residents from abuse are inadequate. No federal statute requires criminal background checks for nursing home employees. Background checks are also not required by the Centers for Medicare and Medicaid Services, which sets the standards that nursing homes must meet to participate in the Medicare and Medicaid programs. State agencies rarely recommend that sanctions be imposed on nursing homes. Although state agencies compile lists of aids who have previously abused residents, which can prevent an aide from being hired at another nursing home, GAO found that delays in making these identifications can limit the usefulness of these registries. This testimony summarizes a March report (GAO-02-312).

Nursing Workforce: Multiple Factors Create Nurse Recruitment and Retention Problems (GAO-01-912T, 27-JUN-01)

While comprehensive data are lacking on the nature and extent of current difficulties recruiting and retaining nurses, current evidence suggests an emerging shortage. Several factors, including nurses' decreased levels of job satisfaction, are combining to constrain the current supply of nurses. Furthermore, like the general population, the nurse workforce is aging, and the average age of a registered nurse (RN) increased from 37 years in 1983 to 42 in 1998. Additionally, enrollments in registered nursing programs have declined over the past 5 years, shrinking the pool of new workers to replace those who are leaving or retiring. The problem is expected to become more serious in the future as the aging of the population substantially increases the demand for nurses.

Retiree Health Insurance: Gaps in Coverage and Availability (GAO-02-178T, 01-NOV-01)

In 1999, about 10 million Americans aged 55 and older relied on employer-sponsored health benefits until they became eligible for Medicare or to pay for out-of-pocket expenses not

covered by Medicare. However, the number of employers offering these benefits has declined considerably during the past decade. Despite the recent strong economy and the relatively low increases in health insurance premiums during the late 1990's, the availability of employer-sponsored health benefits for retirees has declined. Two widely cited surveys found that only about one-third of large employers and less than 10 percent of small employers offer such benefits. Alternative sources of health care coverage for retirees may be costly, limited, or unavailable. Retirees not yet 65 may be eligible for coverage from a spouse's employer or continuation coverage, known as "COBRA," from their former employer. Other retirees not yet 65 may seek coverage in the individual insurance market, but these policies can be expensive or may offer more limited coverage, especially for those with existing health problems. Nearly one-third of retirees eligible for Medicare have employer-sponsored supplemental coverage, but many others buy private supplemental coverage known as "Medigap." It costs an average of $1,300 per year and more for Medigap policies that include prescription drug coverage. Neither Medicare nor private insurance covers a significant share of long-term care expenses.

INCOME SECURITY ISSUES

Private Pensions: Key Issues to Consider Following the Enron Collapse (GAO-02-480T, 27-FEB-02)

The collapse of the Enron Corporation and the resulting loss of employee retirement savings highlighted several key vulnerabilities in the nation's private pension system. Asset diversification was a crucial lesson, especially for defined contribution plans, in which employees bear the investment risk. The Enron case underscores the importance of encouraging employees to diversify. Workers need clear and understandable information about their pension plans to make sound decisions on retirement savings. Although disclosure rules require plan sponsors to provide participants with a summary of their plan benefits and rights and to notify them when benefits are changed, this information is not always clear, particularly in the case of complex plans like floor-offset arrangements. Employees, like other investors, also need reliable and understandable information on a company's financial condition and prospects. Fiduciary standards form the cornerstone of private pension protections. These standards require plan sponsors to act solely in the interest of plan participants and beneficiaries. The Enron investigations should determine whether plan fiduciaries acted in accordance with their responsibilities.

Social Security: Issues in Evaluating Reform Proposals (GAO-02-288T, 10-DEC-01)

This testimony discusses the long-term viability of the Social Security program. Social Security's Trust Funds will not be exhausted until 2038, but the trustees now project that the program's cash demands on the rest of the federal government will begin much sooner. Aiming for sustainable solvency would increase the chance that future policymakers would not have to face these difficult questions on a recurring basis. GAO has developed the following criteria for evaluating Social Security reform proposals: financing sustainable solvency, balancing adequacy and equity, and implementing and administering reforms. These criteria seek to balance financial and economic considerations with benefit adequacy and equity issues and the administrative challenges associated with various proposals. GAO's recent report on Social Security and income adequacy (GAO-02-62) makes three key points. First, no single measure of adequacy provides a complete picture; each measure reflects a different outlook on what adequacy means. Second, given the projected long-term financial shortfall of the program, it is important to compare proposals to both benefits at currently promised levels and benefits funded at current tax levels. Third, various approaches to benefit reductions would have differing effects on adequacy.

Social Security: Long-Term Financing Shortfall Drives Need for Reform (GAO-02-845T, 19-JUN-02)

Social Security not only represents the foundation of our retirement income system; it also provides millions of Americans with disability insurance and survivor's benefits. Although the Social Security Trustees now project that under the intermediate or "best estimate" assumptions the combined Social Security Trust Funds will be exhausted 3 years later than in last year's estimates, the magnitude of the long-term funding shortfall is virtually unchanged.

Without reform, Social Security, Medicare, and Medicaid are unsustainable, and the long-term impact of these entitlement programs on the federal budget and the economy will be dramatic. Social Security reform is part of a larger and significant fiscal and economic challenge. Absent reform, the nation will ultimately have to choose between persistent, escalating federal deficits, significant tax increases, or dramatic budget cuts. Focusing on trust fund solvency alone is not sufficient. Aiming for sustainable solvency would increase the chance that future policymakers would not have to face, on a recurring basis, the difficult questions of whether the government will have the capacity to pay future claims or what else will have to be squeezed to pay those claims. Comparing the beneficiary impact of reform proposals solely to current Social Security promised benefits is inappropriate since all current promised benefits are not funded over the longer term. Reform proposals should be evaluated as packages. If the focus is on the pros and cons of each element of reform, it may prove impossible to build the bridges necessary to achieve consensus. Acting sooner rather than later helps to ease the difficulty of change. Waiting until Social Security faces an immediate solvency crisis will limit the scope of feasible solutions and could reduce the options field to only those choices that are the most difficult and could also delay the really tough decisions on Medicare and Medicaid.

Social Security Administration: Systems Support Could Improve Processing Attorney Fee Payments in the Disability Program (GAO-01-710T, 17-MAY-01)

To ensure that people claiming disability insurance program benefits can obtain legal representation at a fair price, the Social Security Administration (SSA) is required to regulate the fees that attorneys charge people to represent their disability claims before the agency. Balancing the needs of the claimants with those of their attorneys, the law limits the amount of fees that attorneys can charge claimants, but also guarantees that those fees will be paid from the claimants' past-due benefits. Inefficiencies in the current process increase both the time it takes to pay the attorney fees and the cost of administration. One segment of attorney fee processing--the fee approval process--was substantially simplified in 1991. Systems support could streamline the second segment of the processing--the fee payment--thus lowering the annual administrative costs and cutting processing time. Automation of this final segment of the fee process could help improve customer service for both claimants and their attorneys.

VETERANS/DOD ISSUES

VA and Defense Health Care: Potential Exists for Savings through Joint Purchasing of Medical and Surgical Supplies (GAO-02-872T, 26-JUN-02)

The Department of Veterans Affairs (VA) spent $500 million and the Department of Defense (DOD) spent $240 million for medical and surgical supplies in fiscal year 2001. To achieve greater efficiencies through improved acquisition processes and increased sharing of medical resources, VA and DOD signed a memorandum of agreement in 1999 to combine their buying power. VA and DOD saved $170 in 2001 by jointly procuring pharmaceuticals, agreeing on particular drugs to be purchased, and contracting with the manufacturers for discounts based on their combined larger volume. However, VA and DOD have not awarded joint national contracts for medical and surgical supplies as envisioned by their memorandum of agreement, and it is unlikely that the two departments will have joint national contracts for supplies anytime soon. The lack of progress in jointly contracting for medical and surgical supplies has, in part, been the result of different approaches VA and DOD have taken to standardizing medical and surgical supplies. Other impediments to joint purchasing have been incomplete procurement data and the inability to identify similar high-volume, high-dollar purchases. Nevertheless, a few VA and DOD facilities have yielded modest savings through local joint contracting agreements.

VA and DOD Health Care: Factors Contributing to Reduced Pharmacy Costs and Continuing Challenges (GAO-02-969T, 22-JUL-02)

The Department of Veterans Affairs (VA) and the Department of Defense (DOD) pharmacy expenditures have risen significantly, reflecting national trends. The increase in pharmacy costs would have been even greater if not for the efforts taken by VA and DOD. GAO identified four important factors that have contributed to reduced pharmacy spending by VA and DOD. First, the two departments have used formularies to encourage the substitution of lower-cost drugs that are determined to be just as effective as higher-cost drugs. Second, VA and DOD have been able to effectively employ different arrangements to pay for or purchase prescription drugs at substantial discounts. Third, VA has significantly reduced the cost of dispensing prescription refills by using highly automated and less expensive consolidated mail outpatient pharmacy (CMOP) centers to handle a majority of the pharmacy workload. Fourth, VA and DOD have reduced costs by leveraging their combined purchasing power through joint procurement of generic prescription drugs. Nevertheless, one of the most important challenges is the joint procurement of brand name drugs. Although brand name drugs account for the bulk of prescription drug expenditures, most of VA/DOD joint contracts have been for generic drugs. Generic drugs are easier to contract for because these products are already known to be chemically and therapeutically alike. Contracting for brand name drugs is more difficult because of the scientific reviews needed to gain clinical agreement on therapeutic equivalence of competing drugs. Joint purchasing of brand name drugs is also more difficult due to the significant differences between the VA and DOD health care systems in patient populations, national formularies, and prescribing patterns of providers, some of whom are private physicians.

Enclosure I

VA Health Care: Changes Needed to Improve Resource Allocation (GAO-02-685T, 30-APR-02)

The Veterans Equitable Resource Allocation (VERA) system allocated $17.8 billion of its $20.3 billion health care budget to 22 regional health care networks in fiscal year 2001. Before VERA resources were allocated to facilities on the basis of their historical expenditures. By aligning resources with workloads VERA shifted about$921 million among VA's networks in fiscal year 2001. VERA's design is reasonable for equitably allocating resources, but improvements could better allocate comparable resources for comparable workloads. VERA's allocations are based primarily on network workload, with adjustments made for factors beyond the control of network management. These include the health care needs of veterans and some local cost differences. VERA's design also protects patients from the effects of network budget shortfalls. However, GAO found that $200 million annually that could be reallocated to better align network resources with workloads. First, VERA's measurement of network workload is not accurate enough to determine each network's allocation because VERA excludes most veterans with higher incomes who do not have service-connected disabilities--about one-fifth of VA's workload. Second, VERA does not accurately adjust for cost differences among networks for differences in patients' health care needs or case mix across networks. GAO also found that the Veterans Administration has not analyzed whether the networks' need for supplemental resources--provided through the National Reserve Fund--is the result of potential problems in VERA, network inefficiency, or other factors. Without such information, VA can neither ensure the appropriateness of supplemental funding nor take corrective action.

VA Health Care: Changes Needed to Improve Resource Allocation to Health Care Networks (GAO-02-744T, 14-MAY-02)

The Department of Veterans Affairs (VA) spent $21 billion in fiscal year 2001 to treat 3.8 million veterans--most of whom had service-connected disabilities or low incomes. Since 1997, VA has used the Veterans Equitable Resource Allocation (VERA) system to allocate most of its medical care appropriation. GAO found that VERA has had a substantial impact on network resource allocations and workloads. VERA shifted $921 million from networks primarily in the northeast and midwest to networks in the south and west in fiscal year 2001. VERA, along with other VA initiatives, has provided an incentive for networks to serve more veterans. In GAO's view, VERA's overall design is a reasonable approach to allocating resources according to workloads. It provides a predetermined dollar amount per veteran served to each of VA's 22 health care networks. This amount varies depending upon the health care needs of the veteran served and local cost differences. However, GAO identified weaknesses in VERA's implementation. First, VERA excludes about one fifth of VA's workload in determining each network's allocation. Second, VERA does not account well for cost differences among networks resulting from variation in their patients' health care needs. Third, the process for providing supplemental resources to networks through VA's National Reserve Fund has not been used to analyze how the need for such resources is caused by potential problems in VERA's allocation, network inefficiency, or other factors. This testimony is based on an April report (GAO-02-338).

VA Health Care: Community-Based Clinics Improve Primary Care Access (GAO-01-678T, 02-MAY-01)

This testimony discusses the Veterans Health Administration's (VHA) efforts to improve veterans' access to health care through its Community-Based Outpatient Clinics Initiative. Overall, through its clinics, VHA is steadily making primary care more available within reasonable proximity of patients who have used VHA's system in the past. However, the uneven distribution of patients living more than 30 miles from a VHA primary care facility suggests that access inequities across networks may exist. Also, the improvements likely to result from VHA's planned clinics indicate that achieving equity of access may be difficult. In addition, GAO's assessment suggests that new clinics may have contributed to, but are not primarily responsible for, the marked rise in the number of higher-income patients who have sought health care through VHA in recent years. Although the clinics have undoubtedly attracted some new patients to VHA, GAO's analysis suggests that new patients would have sought care at other VHA facilities in the absence of the new clinics. Enhanced benefits and access improvements afforded by eligibility reform may have attracted more new patients, including those with higher incomes.

VA Health Care: Continuing Oversight Needed to Achieve Formulary Goals (GAO-01-998T, 24-JUL-01)

Although the Department of Veterans Affairs (VA) has made significant progress establishing a national formulary that has generally met with acceptance by prescribers and patients, VA oversight has not fully ensured standardization of its drug benefit nationwide. The three medical centers GAO visited did not comply with the national formulary. Specifically, two of the three medical centers omitted more than 140 required national formulary drugs, and all three facilities inappropriately modified the national formulary list of required drugs for certain drug classes by adding or omitting some drugs. In addition, as VA policy allows, Veterans Integrated Service Networks (VISN) added drugs to supplement the national formulary ranging from five drugs at one VISN to 63 drugs at another. However, VA lacked criteria for determining the appropriateness of the actions networks took to add these drugs. In addition to problems standardizing the national formulary, GAO identified weaknesses in the nonformulary approval process. Although the national formulary directive requires certain criteria for approving nonformulary drugs, it does not prescribe a specific nonformulary approval process. As a result, the processes health care providers must follow to obtain nonformulary drugs differ among VA facilities on how requests are made, who receives them, who approves them, and how long it takes to obtain approval. GAO found that the length of time to approve nonformulary drugs averages nine days, but it can be as short as a few minutes in some medical centers. Some VISNs have not established processes to collect and analyze data on nonformulary requests. As a result, VA does not know if approved requests meet its established criteria or if denied requests are appropriate. This testimony summarizes the December 1999 report, HEHS-00-34 and the January 2001 report, GAO-01-183.

VA Long-Term Care: The Availability of Noninstitutional Services Is Uneven (GAO-02-652T, 25-APR-02)

Noninstitutional long-term care services are delivered by the Department of Veterans Affairs (VA) to veterans in their own homes and other community locations. The Veterans Millennium Health Care and Benefits Act requires VA to offer long-term care services to eligible veterans, including services provided in noninstitutional settings. More than two years after the act's passage, VA has yet to offer eligible veterans adult day health care, geriatric evaluation, or respite care. Although VA published proposed regulations that would make these services available in noninstitutional settings to eligible veterans, the regulations had not been finalized as of April 17, 2002. To be responsive before its draft regulations were made final, VA issued a policy directive requiring that these three services be available in noninstitutional settings. GAO found, however, that both the services required by the act and VA's other noninstitutional services were unevenly available across the VA system.

Veterans' Health Care: Observations on VA's Assessment of Hepatitis C Budgeting and Funding (GAO-01-661T, 25-APR-01)

The Department of Veterans Affairs (VA) requested and received $195 million for Hepatitis C screening and treatment in fiscal year 2000. VA's budget documentation showed that it had spent $100 million on Hepatitis C screening and treatment, leaving a difference of $95 million between its estimated and actual expenditures. However, GAO's review revealed that the difference was actually much larger--$145 million. VA's documentation showed that only $50 million was used for budgeted activities and $50 million was used for an activity not included in its original budget--treatment of conditions related to Hepatitis C. It appears that VA is unable to develop a budget estimate that can reliably forecast its Hepatitis C funding needs at this time. However, VA's Veterans Health Administration (VHA) appears to be taking reasonable steps to improve future budget estimates and thereby minimize the potential for large differences. Such steps include developing a Hepatitis C patient registry that could provide the critical data needed to improve budgetary estimates. However, this registry could take as long as 15 months to become operational, which suggests that it may not provide budgetary data in time to formulate the 2004 budget. In the meantime, VHA's ongoing efforts to upgrade its data collection systems should help improve budget estimates for fiscal year 2002. These efforts, however, have provided only minimal help in the development of VA's 2002 budget for Hepatitis C spending. As a result, it is not possible to conclude with certainty whether VA's fiscal year 2002 spending estimate of $171 million is appropriate.

Veterans' Health Care: Standards and Accountability Could Improve Hepatitis C Screening and Testing Performance (GAO-01-807T, 14-JUN-01)

Three years ago, the Department of Veterans Affairs (VA) characterized hepatitis C as a serious national health problem that needs early detection to reduce transmission risks, ensure timely treatment, and prevent progression of liver disease. In a 1988 letter, VA outlined the process clinicians should use when (1) screening veterans for known risk factors for exposure to hepatitis C and (2) ordering tests to detect antibodies and diagnose hepatitis C infection as part of a plan to evaluate and assess risk factors for VA patients. This testimony

discusses VA's progress in screening and testing veterans for hepatitis C during fiscal years 1999 and 2000. GAO found that VA missed opportunities to screen as many as three million veterans when they visited medical facilities during fiscal years 1999 and 2000, potentially leaving as many as 200,000 veterans unaware that they have hepatitis C infections. Of those screened, an unknown number likely remain undiagnosed because of flawed procedures. Although the pace of screening and testing appears to be improving, many currently undiagnosed veterans may not be identified expeditiously unless VA (1) establishes early detection of hepatitis C as a standard for care and (2) holds facility managers accountable for timely screening and testing of veterans who visit VA medical facilities.

OTHER ISSUES

Budget Issues: Long-Term Fiscal Challenges. (GAO-02-467T, 27-FEB-02)

Combating terrorism and ensuring homeland security have created urgent claims on the nation's attention and on the federal budget. At the same time, the fiscal pressures created by the retirement of the baby boomers and rising health care costs continue unchanged. Because the longer-term outlook is driven in large part by known demographic trends, the outlook 20 years from now is surer than the forecast for the next few years. The message of GAO's updated simulations remains the same: absent structural changes in entitlement programs for the elderly, persistent deficits and escalating debt will overwhelm the budget in the long term. Both longer-term and new commitments undertaken after September 11 sharpen the need for careful scrutiny of competing claims and new priorities. A fundamental review of existing programs and activities is necessary both to increase fiscal flexibility and to make government fit the modern world. Stated differently, there is a need to consider the proper role of the federal government in the 21st century and how government should do business. The fiscal benchmarks and rules that moved the country from deficit to surplus expire this fiscal year. Any successor system should include a debate about reprioritization today and a better understanding of the long-term implications of different policy choices. Many things that the nation may be able to afford today may not be sustainable in the future.

Homelessness: Improving Program Coordination and Client Access to Programs. (GAO-02-485T, 06-MAR-02)

Many people are homeless for only a short time and get back on their feet with minimal assistance, but others are chronically homeless and need intensive and ongoing assistance. Fifty federal programs exist to help the homeless with housing. Sixteen of these are targeted exclusively to the homeless, and the others are mainstream programs. Targeted programs were funded at $1.7 billion in fiscal year 2001. GAO found that the Department of Housing and Urban Development (HUD) has been unable to ensure that adequate coordination occurs among the programs without creating undue administrative burdens for the states and communities. Steps have been taken to improve the coordination of homeless assistance programs within communities and to reduce some of the administrative burdens caused by separate programs. Although low-income populations face barriers to obtaining services provided by mainstream programs, these barriers are compounded by homelessness. In addition, the underlying structure and operations of federal mainstream programs do not ensure that the special needs of homeless people are met. Consolidating HUD's McKinney-Vento programs could help reduce the administrative burden. However, to end chronic homelessness in 10 years, federal agencies must strive to eliminate the barriers that homeless people encounter as they seek services from mainstream programs.

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ITEM 19—LEGAL SERVICES CORPORATION

In 2001, LSC-funded programs served approximately 1 million clients. Fourteen percent, or just over 140,000 individuals served were age sixty or over. In 2002, LSC-funded programs served slightly fewer than 1 million clients. More than 100,000 of those clients, or over 10 percent, were age sixty or over.

Many of the type of cases handled by LSC funded programs directly impact the lives of seniors. Consumer cases, which include bankruptcy, repossessions, public utilities and unfair sales practices totaled more than 11 percent of the cases handled by federally funded legal services programs in 2001 and 2002. Health cases, including Medicare and Medicaid cases, totaled approximately 3 percent of cases closed by legal services programs during that time period. In 2001 and 2002, housing cases, including landlord/tenant cases and public housing cases, made up nearly 25 percent of the cases closed by LSC-funded programs. Income Maintenance cases, including black lung, food stamps, Veterans benefits and Social Security, made up roughly 13 percent of the cases handled by legal services programs in 2001 and 2002. Seniors make up some portion of the clients served in each of these types of case.

ITEM 20_PENSION BENEFIT GUARANTY CORPORATION
Washington, DC 20005-4026 www.pbgc.gov

News Release

FOR IMMEDIATE RELEASE
January 15, 2004

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News Division, 202-326-4040

PBGC Releases Fiscal Year 2003 Financial Results

The Pension Benefit Guaranty Corporation's insurance program for pension plans sponsored by a single employer suffered a net loss of $7.6 billion in fiscal year 2003, according to the agency's Annual Report released today. As a result, the program's fiscal year-end deficit worsened to a record $11.2 billion, three times larger than any previously recorded deficit.

"The continued erosion of PBGC's financial condition underscores the need for comprehensive reforms to put pension plans on a path to better funding," said Executive Director Steven A. Kandarian. "While the PBGC has sufficient assets to pay benefits to workers and retirees for a number of years, the growing gap between our assets and liabilities puts at risk the agency's ability to continue to protect pensions in the future."

The PBGC's single-employer program insures the pensions of 34.5 million Americans in 29,500 plans. Of the $7.6 billion net loss for 2003, the two biggest factors were a $5.4 billion loss from completed and probable pension plan terminations, and a $4.3 billion loss due to declining interest rates.

Partially offsetting the single-employer program's losses were premium income of $948 million and investment income of $3.3 billion. Overall, including the assets of terminated plans for which PBGC took responsibility during the year, the single-employer program had $34 billion in assets to cover $45.3 billion in liabilities. The previous year, the program had $25.4 billion in assets to cover $29 billion in liabilities.

Single-Employer Program Exposure

In addition to losses already incurred, the PBGC calculates "reasonably possible" exposure, an estimate of the amount of unfunded vested benefits in pension plans sponsored by financially weak employers. The 2003 Annual Report estimates that PBGC's reasonably possible exposure is $85.5 billion, nearly two and a half times higher than the previous year's estimate of $35.4 billion. Two industries—air transportation at $23.4 billion and primary metals & fabricated metal products at $10.2 billion—account for nearly 40 percent of the total.

PBGC's Multiemployer Insurance Program

The PBGC's separate insurance program for multiemployer pension plans sustained a net loss of $419 million in fiscal year 2003, resulting in fiscal year-end deficit of $261 million. This was the program's first deficit in more than 20 years and its largest deficit ever.

The multiemployer program covers 9.7 million participants in more than 1,600 plans. The sharp reversal in the program's financial condition is due largely to a decline in interest rates and the recording of new probable losses for plans that are projected to become insolvent and require financial assistance from PBGC to pay benefits. The multiemployer program has $1 billion in assets and receives $25 million a year in premium income. PBGC estimates that total underfunding in multiemployer plans is roughly $100 billion.

"This underfunding prompts an additional concern for the multiemployer program because the underfunding is concentrated in mature, often declining industries," Kandarian said. "Given the limited size of the multiemployer program, the failure of a large, highly underfunded plan could overwhelm the program's financial capacity."

Other Key Facts from the FY 2003 Annual Report

- The PBGC became trustee of 152 pension plans covering 206,000 people, up from 144 plans and 187,000 participants the year before. This was the largest one-year increase in the total number of people owed guaranteed benefits by the agency.
- The total number of participants owed or receiving guaranteed benefits from the PBGC, including participants in multiemployer plans receiving financial assistance, rose to 934,000 from 783,000.
- The PBGC paid a record $2.5 billion in benefits, nearly $1 billion more than in 2002.
- Premium income rose to $973 million from $812 million the year before.
- PBGC's total return on invested assets was a positive 10.3 percent in 2003 compared with 2.1 percent in 2002.

The PBGC's financial statements for fiscal year 2003 received an unqualified audit opinion for the 11th consecutive year. The audit was performed by PricewaterhouseCoopers LLP under the direction and oversight of the agency's Inspector General.

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PBGC No. 04-20


P B G C
PENSION BENEFIT GUARANTY CORPORATION
2005 ANNUAL REPORT

[illegible] protects the pensions of nearly 44.3 million working men and women in more than 31,000 private defined benefit pension plans, including 34.5 million people covered by 29,500 single-employer plans and more than 9.7 million people covered by over 1,600 multiemployer plans. These pension plans provide a specified monthly benefit at retirement, usually based on salary or a stated dollar amount and years of service. The Employee Retirement Income Security Act of 1974 established PBGC as a federal corporation. PBGC operates under the guidance of its Board of Directors, which consists of the Secretaries of Labor (Chair), Commerce, and the Treasury.

PBGC receives no funds from general tax revenues. Operations are financed by insurance premiums set by Congress and paid by sponsors of defined benefit plans, investment income, assets from pension plans trusteed by PBGC, and recoveries from the companies formerly responsible for the plans.

PBGC's mission is to operate as a service-oriented, professionally managed agency that protects participants' pension benefits and supports a healthy retirement plan system by:

- encouraging the continuation and maintenance of voluntary private pension plans for the benefit of their participants,
- providing timely payments of benefits in the case of terminated pension plans, and
- making the maximum use of resources and maintaining premiums and operating costs at the lowest levels consistent with statutory responsibilities.

Contents

Defined benefit pension plans remain the cornerstone of retirement security for millions of American workers and retirees. Unfortunately, the defined benefit system is now confronted with the most significant challenges it has faced in over a decade. As of the end of fiscal year 2003, total underfunding in America's private pension plans exceeded $350 billion, by far the largest fiscal year-end number ever recorded. At the Pension Benefit Guaranty Corporation, not only did the single-employer insurance program show a record $11.2 billion deficit, but the multiemployer insurance program fell into deficit for the first time in over 20 years.

While PBGC is not in crisis—the agency has sufficient assets to meet its obligations for a number of years into the future—it is clear that the financial integrity of the federal pension insurance system is at risk. It is equally clear that comprehensive reform of the nation's pension funding rules must be enacted to strengthen the financial health of the defined benefit pension system.

This Administration has already proposed several initiatives as a first step toward responsible reform of the pension funding rules, including a more accurate measure of pension liabilities, improved disclosure of pension information, and new safeguards against underfunding. However, more is needed. The Administration will be working closely with Congress to develop a broad package of reforms to put PBGC and the defined benefit system on a sustainable path for the long term.

Despite its growing financial concerns, PBGC is responding to its work with professionalism and a commitment to providing outstanding service to its customers. PBGC is enhancing its productivity and efficiency, and its employees continue to explore ways to improve service through better use of technology and other means.

More than 900,000 workers and retirees now rely on PBGC to pay their pensions. But the existing regime cannot protect all the benefits currently at risk in the private defined benefit pension system. For that, we need new funding rules to ensure that pension promises made are pension promises kept.

Elaine L. Chao
Secretary of Labor
Chairman of the Board

- The single-employer program suffered significant losses from completed and probable plan terminations and interest rate changes that drove its deficit to a record high of $11.2 billion. The net loss for the year totaled $7.6 billion, down from the $11.4 billion recorded in 2002. At the same time, the program's total assets of $34.0 billion assure the Corporation's ability to meet its obligations for a number of years.

(Dollars in millions)	**2003**	2002
SINGLE-EMPLOYER AND MULTIEMPLOYER PROGRAMS COMBINED		
Premium Income	**$ 973**	$ 812
Losses from Plan Terminations	**$ 5,377**	$ 9,313
Investment Income	**$ 3,386**	$ 288
Actuarial Charges and Adjustments	**$ 6,162**	$ 2,802
Benefits Paid	**$ 2,489**	$ 1,538
Retirees	**459,190**	344,770
Total Participants Receiving or Owed Benefits	**934,000**	783,000
New Underfunded Terminations	**155**	157
Terminated/Trusteed Plans (Cumulative)	**3,287**	3,132
SINGLE-EMPLOYER PROGRAM		
Total Assets	**$ 34,016**	$ 25,430
Total Liabilities	**$ 45,254**	$ 29,068
Net Loss	**$ (7,600)**	$(11,370)
Net Position	**$(11,238)**	$ (3,638)
MULTIEMPLOYER PROGRAM		
Total Assets	**$ 1,000**	$ 944
Total Liabilities	**$ 1,261**	$ 786
Net Income (Loss)	**$ (419)**	$ 42
Net Position	**$ (261)**	$ 158

- PBGC absorbed the largest single plan (95,000 participants) and largest loss from one company in its history (about $3.6 billion) with its trusteeship of the Bethlehem Steel pension plan. PBGC continues to face significant exposure from troubled companies with underfunded pension plans, especially in the air transportation and steel sectors, the termination of which could produce substantial additional losses.

- PBGC paid nearly $2.5 billion in benefits during the year, a new record for annual benefit payments that exceeded the previous record amount (paid in 2002) by almost $1 billion.

- In 2003, PBGC became trustee of 152 terminated single-employer plans covering about 206,000 people, up from 144 plans and 187,000 participants in 2002. This was the largest one-year increase in the total number of people owed guaranteed benefits by the Corporation. A total of 155 underfunded plans terminated during the year.

- At year-end, PBGC was responsible for the pensions of more than 930,000 people—more than 459,000 who are currently receiving benefits, another 375,000 who will begin to receive benefits when they retire in the future, and 100,000 who are receiving or will receive benefits due to PBGC's financial assistance to multiemployer plans. Despite dramatic growth in its workload, the Corporation further reduced the average time needed to issue final benefit determinations, significantly exceeding its annual performance target.

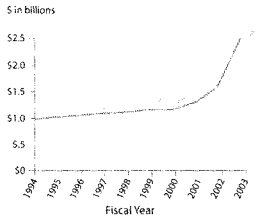
- The multiemployer program reported a year-end deficit of $261 million, its first deficit in more than 20 years and largest deficit ever, primarily because PBGC recorded substantial additional probable losses from expected nonrecoverable future financial assistance.

- PBGC advanced its electronic government initiatives with tests of its first online self-service centers and first fully electronic business transactions. PBGC expects to implement its initial production versions of both during 2004.

- PBGC recorded investment income of $3.4 billion in 2003 as the relative performance of equity and fixed-income investments was reversed from 2002. PBGC's total return on investments was a positive 10.3% in 2003 compared to 2.1% in 2002.

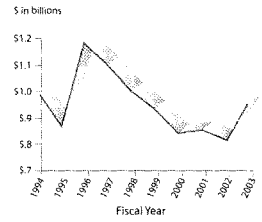
- PBGC's annual performance report (pp. 12-16) describes gains in both productivity and customer satisfaction.

Annual Benefit Payments 1994-2003



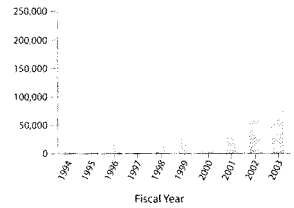
PBGC's benefit payments increased 62 percent from 2002, reaching a total of nearly $2.5 billion.

Total Premium Revenue 1994-2003



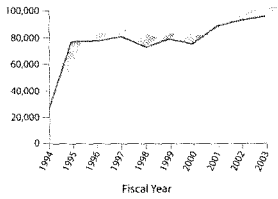
Premium revenues increased 20 percent from 2002, reaching a total of $973 million.

Participants in Trusteed Plans 1994-2003



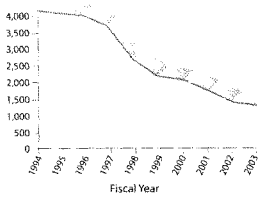
PBGC took responsibility for the benefits of a record 206,000 new participants during the year.

Benefit Determinations Issued 1994-2003



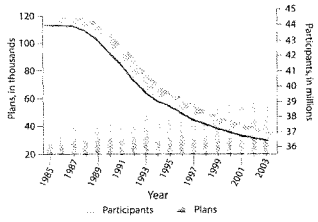
PBGC issued more final benefit determinations in 2003 than in any prior year, lowering the average age of the determinations issued to about 2.2 years.

Standard Terminations 1994-2003



Only 1,119 standard terminations were submitted to PBGC during 2003, fewer than any previous year. There have been more than 164,000 standard terminations since 1974, leaving only 31,000 plans active at present.

PBGC-Insured Plans and Participants 1985-2003



The number of PBGC-insured plans continued to decline, falling to about 31,000, although there continued to be slight growth in the number of covered participants.

Steven A. Kandarian
Executive Director

Following the historic losses recorded by the pension insurance program in 2002, the Pension Benefit Guaranty Corporation (PBGC) sustained additional severe losses during 2003 amid deepening concern for the health of the private defined benefit pension system. Defined benefit pension plans continue to be an important source of retirement security for more than 44 million American workers. However, the funded status of these plans has deteriorated sharply and a number of plan sponsors have been unable to meet their benefit obligations, leading to record deficits in both of PBGC's insurance programs. Despite the financial pressures on the Corporation, PBGC continued to meet the growing demand placed upon it for benefit payments while making further progress in customer service.

LOSSES CONTINUED

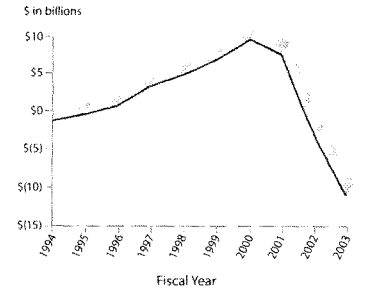
Under PBGC's single-employer plan insurance program, losses from completed and probable plan terminations totaled nearly $5.4 billion for 2003, significantly less than the record amount experienced in 2002. This represented PBGC's second largest annual loss from plan terminations in its 29-year history, continuing a three-year-old trend of steep losses for the pension insurance program.

These losses represent more than just claims against the insurance program. When PBGC is forced to take over underfunded plans, the burden often falls heavily on workers and retirees. In some cases, participants lose benefits that were earned but not guaranteed by the insurance program. In all cases, workers lose the opportunity to earn additional benefits under the terminated plan.

PBGC's premium payers—the employers who sponsor defined benefit pension plans—also pay a price when an underfunded plan terminates. When PBGC takes over such plans, financially healthy companies with better-funded pension plans end up making transfers to financially weak companies with chronically underfunded plans.

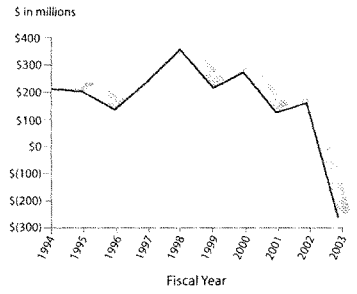
In a counterpoint to PBGC's losses from terminations, the Corporation's investment program produced income in excess of $3.3 billion. However, as substantial as it was, the Corporation's investment income only offset about half of the actuarial charges arising largely from interest rate changes. Even with the investment income, PBGC is reporting a net loss for the year of $7.6 billion primarily due to losses from terminated plans and actuarial charges, pushing the single-employer program's year-end deficit to $11.2 billion. At year-end the total liability for guaranteed benefits exceeded $44.6 billion compared to less than $29 billion one year ago.

NET POSITION, SINGLE-EMPLOYER PROGRAM
1994-2003



PBGC's separate insurance program for multiemployer plans, which is vulnerable to some of the same economic and demographic pressures that have threatened the single-employer program, also sustained a substantial loss for the year. The multiemployer program reported

NET POSITION, MULTIEMPLOYER PROGRAM
1994-2003



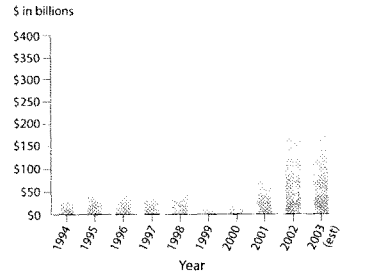
a net loss of $419 million, the largest one-year drop in the program's history. This result is largely due to PBGC's recording of new probable losses from future financial assistance for several additional plans as well as from the decline in interest rates. Consequently, the multiemployer program is reporting a year-end deficit of $261 million, the program's largest shortfall ever and its first year-end deficit in over 20 years.

The financial state of both insurance programs is cause for concern. The single-employer program's $34 billion in assets, and the multiemployer program's $1 billion in assets, provide PBGC with sufficient liquidity to pay benefits for a number of years. However, neither program at present has the resources to fully satisfy PBGC's long-term obligations to plan participants. Moreover, PBGC estimates that the total underfunding in single-employer plans exceeded $350 billion as of fiscal year-end. Underfunding in multiemployer plans has increased as well, reaching an estimated $100 billion as the year closed. This underfunding prompts an additional concern for the multiemployer program because the underfunding is concentrated in mature, often declining industries. Given the limited size of the multiemployer program, the failure of a large, highly underfunded plan could overwhelm the program's financial capacity.

The Bush Administration has recognized the urgency of the financial challenges facing private pension plans and PBGC's insurance programs and has alerted the public to its concerns. The Administration's concerns were affirmed in 2003 when the General Accounting Office (GAO) placed PBGC's single-employer program on its "high-risk" list. It should be noted that GAO's action did not reflect concerns about management of the pension insurance program, as GAO pointed out in Congressional testimony. Rather, GAO's report to the Congress pointed to structural problems in the private-sector defined benefit system that pose serious risks to PBGC.

The funding of America's private pension plans is a pressing public policy issue. Financial market trends from 2000 through 2002—falling interest rates and equity returns—have exposed underlying weaknesses in the pension system, weaknesses that must be corrected if the system is to remain viable in the long run. The defined benefit system faces other challenges as well, including an asset-liability mismatch, adverse demographic trends, and weaknesses in the pension funding rules.

TOTAL UNDERFUNDING IN
INSURED SINGLE-EMPLOYER PLANS
1994-2003

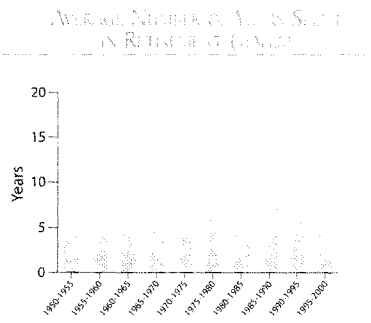


The concurrent drops in both equity values and interest rates, in particular, have undermined the financial strength of most defined benefit pension plans in recent years. Pension plan liabilities tend to be bond-like in nature. For example, both the value of bonds and the value of pension liabilities have risen in recent years as interest rates fell. Were interest rates to rise, both the value of bonds and the value of pension liabilities would fall. The value of equity investments is more volatile than the value of bonds and less correlated with interest rates. Most companies prefer equity investments because they have historically produced a higher rate of return than bonds. These companies are willing to accept the increased risk of equities and interest rate changes in exchange for expected lower pension costs over the long term. Similarly, labor unions support investing in equities because they believe it results in larger pensions for workers. Investing in equities rather than bonds shifts some of these risks to PBGC.

Demographic trends are another structural factor adversely affecting defined benefit plans. Many defined benefit plans are sponsored by employers in the nation's oldest and most capital intensive industries. These industries face growing pension and health care costs due to an increasing number of older and retired workers. Retirees already outnumber active workers in some industries with substantially underfunded plans. Furthermore, Americans are living longer in retirement as a result of earlier retirement and longer life spans. Today, an average male worker spends 18.1 years in retirement compared to 11.5 in 1950, an additional 7 years of retirement that must be funded.

Another concern is weaknesses in the current funding rules, most notably the low limits set for funding targets. Employers can stop making contributions when a pension plan is funded at 90 percent of "current liability." However, current liability doesn't reflect the plan's termination liability, which is the full cost of providing annuities as measured by group annuity prices in the private market. For example, in its last filing prior to termination, Bethlehem Steel reported that it was 84 percent funded on a current liability basis. At termination, however, the plan was only 45 percent funded on a termination basis, with total underfunding of $4.3 billion.

The funding rules also often allow "contribution holidays" even for seriously underfunded plans. For example, in the case of the U.S. Airways pension plan for pilots, which PBGC trusteed in March with unfunded benefits totaling $2.2 billion, the company made no cash contributions to the plan for four years prior to plan termination. And, because of the structure of the funding rules under ERISA and the Internal Revenue Code, defined benefit plan contributions can be extremely volatile. After years of the funding rules allowing companies to make little or no contributions, many companies are facing substantial increases in their contributions at a time when they are facing other economic pressures.



Fundamental changes in the funding rules are needed to put plans on a predictable, steady path to better funding. At the same time, we

must keep in mind that the defined benefit pension system is voluntary. We must balance reforms against any new disincentives for companies to maintain their pension plans. By strengthening the funding rules to minimize volatility in contribution requirements but still ensure that all companies make the contributions needed to back their pension promises, we will make it more attractive for plan sponsors to retain their defined benefit plans.

The Administration believes that the first step toward responsible reform of pension funding rules is to improve the accuracy and transparency of pension information. To this end, the Administration has proposed an initial package of legislative reforms to respond to the challenges facing the defined benefit system. The proposals include specific recommendations to more accurately value pension liabilities, to increase disclosure about the funded status of plans, and to require immediate funding of additional benefits in severely underfunded plans at high risk of termination.

In addition to these proposals, the Administration is developing comprehensive reforms to strengthen the defined benefit system by getting pension plans better funded. We also believe that PBGC's premiums should be re-examined to see whether they can better reflect the risk posed by various plans to the pension system as a whole.

BENEFIT OPERATIONS EXPANDED

In addition to our growing financial concerns, we also are coping with unprecedented growth in our benefit operations. In the past two years, PBGC has assumed responsibility for the benefits of nearly 400,000 people, equal to the number the Corporation took in during its first 21 years of operation. PBGC took on responsibility for some 206,000 workers and retirees in 152 plans trusteed during 2003 alone. This was the largest number of new beneficiaries ever absorbed in one year by the insurance program, topping the previous record set just last year. The trusteed plans also included the largest single plan ever handled by PBGC, that of Bethlehem Steel Corporation, which covered 95,000 participants including 67,000 retirees.

By the end of 2003, PBGC was responsible for a total of 3,240 trusteed plans and the current and future pension benefits of about 934,000 participants, including 100,000 participants in multiemployer plans receiving financial assistance from PBGC. An additional 47 terminated single-employer plans were pending trusteeship at year-end.

During 2003, PBGC paid benefits totaling nearly $2.5 billion to more than 459,000 people. This was up from the previous record amount of $1.5 billion, paid in 2002, and it was $1.4 billion more than we paid just two years ago.

PBGC's insurance program for multiemployer plans approved requests for financial assistance from two additional plans during 2003. These requests raised to 33 the total number of plans that have received financial assistance from PBGC, out of the more than 1,600 insured plans. Since 1980, PBGC has provided assistance with a total value of approximately $162 million net of repaid amounts. During the year, 24 plans received financial assistance totaling about $5 million.

CUSTOMER SERVICE IMPROVED

Although faced with a huge surge in new people owed guaranteed benefits, PBGC increased its performance in issuing final benefit determinations. During 2003, the

Corporation issued over 92,000 benefit determinations, more than in any previous year. On average, PBGC issued the final determinations only 2.2 years after the date it had trusteed the participant's plan, exceeding the performance goal of a 3-year average set for 2003 under PBGC's strategic plan. This was the shortest amount of time the Corporation has ever needed to produce final benefit determinations, achieved despite the historic increase in PBGC's workload.

Our recent efforts to improve efficiency have also contributed to improved customer service. Procedural innovations applied and tested in the termination of the LTV Steel plans in 2002, such as advance coordination with the plan sponsor before the plan's actual termination, early communications with plan participants, and specialized customer contact centers, helped ensure a virtually seamless transition to PBGC trusteeship in spite of the plans' unusually large size. The new procedures and lessons learned from LTV were applied on a greater scale in 2003, allowing PBGC to absorb Bethlehem Steel's even larger plan without compromising our customer service or processing goals. Another recent improvement—accelerated issuance of benefit determinations for people whose benefits are uncomplicated or unaffected by adjustments—enabled PBGC to increase its output of final determinations to cope with the growing demand. These innovations have markedly improved productivity and efficiency. Consequently, PBGC's customers are receiving higher quality service, as their increasing satisfaction attests (please see the Annual Performance Report, later in this Annual Report, for details).

Further improvements in customer service will be achieved through greater use of information technology. Our electronic government initiative, including Web-based methods of communication, will strengthen PBGC's ability to provide premier service for its rapidly growing customer base.

Throughout 2003, PBGC continued efforts to develop fully functional online self-service centers. Once implemented, these accounts will enable participants in trusteed plans and plan practitioners to access their personal or plan-related information and conduct a range of transactions any time of day on any day of the year. Late in 2003 PBGC initiated a small-scale test of a pilot self-service center for participants called "My Pension Benefit Account" that allows online updating of certain personal information. PBGC also began testing and refining a prototype of a similar self-service facility, called "My Plan Administration Account," for administrators of PBGC-insured plans and the pension practitioners who assist them. The Corporation plans a phased rollout of initial versions of these self-service accounts to its customers beginning in 2004.

PBGC is also pressing forward with other initiatives aimed at upgrading its information technology and enhancing its service capabilities. We have begun testing a Customer Relationship Management (CRM) application that uses a combination of technology and streamlined business processes to improve PBGC's responsiveness to customer inquiries. During this past year PBGC also implemented a new Knowledge Management application that allows PBGC's operations staff to preserve and easily share knowledge about innovations and lessons learned in processing the recent large plan terminations.

Customer service at PBGC is a dynamic concept grounded on continual improvement, and we are looking ahead to other projects that have significant implications for PBGC and its customers. For example, we are

re-engineering the business processes for premium payments and standard terminations as the first step in redesigning the Corporation's automated premium accounting system to better serve plan practitioners. Other projects for which planning is underway include integration of PBGC's financial systems, improved automated systems for performing plan valuations and benefit calculations, and application of independent verification and validation testing to all of the Corporation's major automated systems.

While many of our initiatives are driven by our business needs, others arise from customer comments. We now use the American Customer Satisfaction Index (ACSI) to measure our customers' satisfaction with our services and to gain insight into needed improvements. The ACSI index is a sophisticated, internationally accepted index compiled annually from surveys by a partnership of the University of Michigan Business School, the American Society for Quality and the CFI Group. It offers an independent, objective third-party measure that can help PBGC identify and prioritize areas needing improvement. PBGC's latest ACSI scores, described later in the Annual Performance Report section of this Annual Report, demonstrate the progress we are making in addressing our customers' needs and wants.

FINAL THOUGHTS

The federal pension insurance system and the pension plans it protects now face serious challenges. PBGC's staff is responding with increased efficiency, productivity, and concern for the needs of our customers. However, fundamental changes are needed to put the defined benefit system and PBGC's insurance program on a stable long-term footing. The Bush Administration is actively engaged in formulating appropriate solutions and we will be working with Congress to craft the necessary reforms. The retirement security of American workers demands no less.

Steven A. Kandarian
Executive Director

PBGC's "expected claims" are dependent on two factors: the amount of underfunding in the pension plans that PBGC insures (i.e., exposure) and the likelihood that corporate sponsors of these underfunded plans encounter financial distress that results in bankruptcy and plan termination (i.e., the probability of claims).

Over the near term, expected claims result from underfunding in plans sponsored by financially weak firms. PBGC treats a plan sponsor as financially weak based upon factors such as whether the firm has a below-investment-grade bond rating. PBGC calculates the underfunding for plans of these financially weak companies using the best available data, including the annual confidential filings that companies with large underfunded plans are required to make to PBGC under Section 4010 of ERISA.

For purposes of its financial statements, PBGC classifies the underfunding of financially weak companies as "reasonably possible" exposure, as required under accounting principles generally accepted in the United States of America. The "reasonably possible" exposure as of September 30, 2003, as disclosed in Note 7 of the financial statements, ranged from $83 billion to $85 billion (valued using data as of December 31, 2002), compared to $35 billion for fiscal year 2002.

Over the longer term, exposure and expected claims are more difficult to quantify either in terms of a single number or a limited range. Claims are sensitive to changes in interest rates and stock returns, overall economic conditions, the development of underfunding in some large plans, the performance of some particular industries, and the bankruptcy of a few large companies. Large claims from a small number of terminations and volatility characterize the Corporation's historical claims experience and are likely to affect PBGC's potential future claims experience as well.

METHODOLOGY FOR CONSIDERING LONG-TERM SINGLE-EMPLOYER PROGRAM CLAIMS

No single underfunding number or range of numbers—even the reasonably possible estimate—is sufficient to evaluate PBGC's exposure and expected claims over the next 10 years. There is too much uncertainty about the future, both with respect to the performance of the economy and the performance of the companies that sponsor insured pension plans.

PBGC uses a stochastic model—the Pension Insurance Modeling System (PIMS)—to evaluate its exposure and expected claims.

PIMS portrays future underfunding under current funding rules as a function of a variety of economic parameters. The model recognizes that all companies have some chance of bankruptcy and that these probabilities can change significantly over time. The model also recognizes the uncertainty in key economic parameters (particularly interest rates and

stock returns). The model simulates the flows of claims that could develop under thousands of combinations of economic parameters and bankruptcy rates. (For additional information on PIMS and the assumptions used in running the model, see PBGC's *Pension Insurance Data Book 1998*, pages 10-17, which also can be viewed on PBGC's Web site at **www.pbgc.gov/publications/databook/databk98.pdf.**)

PIMS starts with data on PBGC's net position (an $11.2 billion deficit in the case of FY 2003) and data on the funded status of approximately 350 plans that is weighted to represent the universe of PBGC-covered plans. The model produces results under 5,000 different simulations.

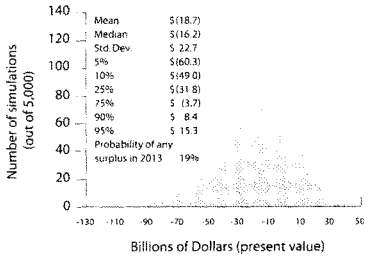
Under the model, median claims over the next 10 years will be about $2.2 billion per year (expressed in today's dollars); that is, half of the simulations show claims above $2.2 billion per year and half below. The mean level of claims (that is, the average claim) is higher, about $2.6 billion per year. The mean is higher because there is a chance under some simulations that claims could reach very high levels. For example, under the model there is a 10 percent chance that claims could exceed $4.7 billion per year.

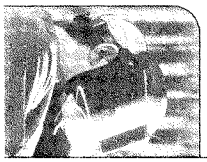
PIMS then projects PBGC's potential financial position by combining simulated claims with simulated premiums, expenses, and investment returns. The probability of a particular outcome is determined by dividing the number of simulations with that outcome by 5,000.

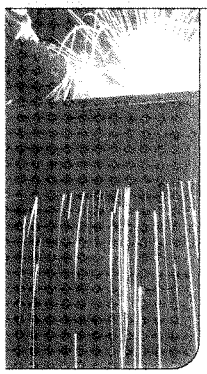
The median outcome is a $16.2 billion deficit in 2013 (in present value terms). This means that half of the simulations show either a smaller deficit than $16.2 billion, or a surplus, and half of the simulations show a larger deficit. The mean outcome is an $18.7 billion deficit in 2013 (in present value terms).

The median projected financial position is lower than last year's median projection, both of which were based on a wide range of possible outcomes for each year of the projection. The drop in the median projection is attributable to several factors. PBGC's own financial position eroded by $7.6 billion during 2003. Despite some improvement in plan asset returns over the year, total underfunding increased in PBGC-covered plans due to a further drop in interest rates. Further, the increase in underfunding in plans of financially weak companies—almost two and a half times the 2002 values—was even greater than the increase in total underfunding.

The graph below illustrates the wide range of outcomes that are possible for PBGC over the next 10 years. The other statistics listed on the graph give further details on the distribution of outcomes. The standard deviation is a measure of how widely the distribution is spread over its range and the percentiles indicate the likelihood of a position below particular values. For example, the model shows a 10 percent chance that the deficit could be as large as $49.0 billion and a 10 percent chance that PBGC could have a surplus of $8.4 billion or more. The probability of a surplus of any amount in 2013 is 19 percent.







PBGC's current five-year strategic plan has four broad goals that form the framework of the Corporation's short- and long-term plans. The PBGC goals are to:

- protect existing defined benefit plans and their participants;
- provide high quality, responsive services and accurate and timely payment of benefits to participants;
- strengthen financial programs and systems to keep the pension insurance system solvent; and
- improve internal management support operations.

PBGC's performance measures track specific results that are significant to its customers and gauge PBGC's solvency and customer service accomplishments. For 2003 PBGC added measures for benefit accuracy and monitoring ongoing pension plans. PBGC also dropped two measures where it had effectively reached the upper limit of performance: for premium collection (99 percent in 2002) and the age of pre-trusteeship inventory (an average age of well below one year in 2002).

PBGC is in the process of revising its strategic plan for fiscal years 2004-2008. That new plan will reflect two revised strategic goals and new performance measures focused on customer satisfaction, underfunding of insured pension plans and PBGC's cost-effectiveness.

PBGC's strategic plan may be found on PBGC's Web site at **www.pbgc.gov/about/stratplan.htm**. The following table shows the results achieved in 2003 and meets the annual reporting requirement of the Government Performance and Results Act.

2003 PBGC Corporate Performance Measures

Measure	Applicable Goal	2003 Milestone	2003 Result	Baseline[a]
Protect the interests of defined benefit pension plan participants by:				
◘ Monitoring companies sponsoring defined benefit pension plans, and reviewing their transactions.	(1)	[b]	902 controlled groups 2,917 plans	902 controlled groups 2,917 plans (2003)
◘ Resolution of bankruptcy actions with companies sponsoring plans	(1)	[b]	172 plans 676,899 participants	92 plans 226,000 participants (1999)
Customer Satisfaction:				
◘ American Customer Satisfaction Index of participants who contact PBGC for service	(2)	74	77	73 (2001)
◘ American Customer Satisfaction Index of pension practitioners who contact PBGC for service	(2)	70	69	69 (2002)
Operations:				
Send benefit determinations to participants in defined benefit pension plans taken over by PBGC within 3.0 years, on average	(2)	3 years	2.2 years	5.95 years (1997)
Make trusteeship decisions within one year of opening the case for non-bankruptcy reportable events	(2)	90%	92%	94% (2002)
Send the first benefit payment to an eligible person within 3 months of receiving his/her completed application	(2)	95%	97%	83% (1999)
Find and pay benefits to missing participants in terminated defined benefit plans	(2)	[b]	7,729 participants	1,303 participants (1999)
Assure the accuracy of benefit determinations based on an audit of benefit determination letters (BDLs) issued	(2)	[c]	Issued Statement of Reasonable Assurance of Accuracy	Issued Statement of Reasonable Assurance of Accuracy (2003)
Financial Management:				
Research and respond within 90 days to requests for premium refund, waiver of premium penalty, and reconsideration of a PBGC premium decision	(3)	85%	82%	26% (2001)
Approximate comparable 5-year investment indices for PBGC's portfolio performance	(3)	[b]	PBGC Index *Equities* 2.1% 2.0% *Fixed-Income* 6.5% 6.5%	(1997) PBGC Index *Equities* 20.6% 20.6% *Fixed-Income* 10.9% 8.9%

a/ Year in parenthesis indicates the year in which the baseline value was set.

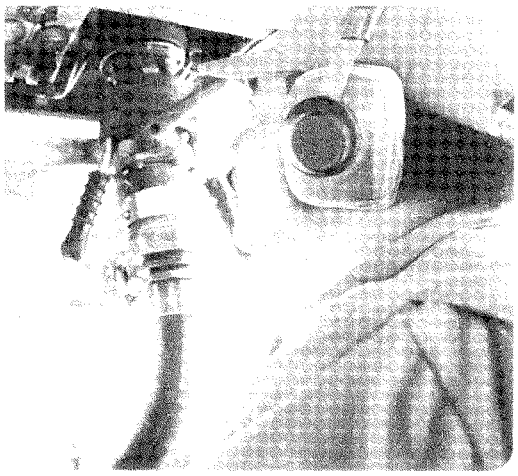
b/ By their nature, these measures do not lend themselves to setting annual targets or milestones. PBGC measures performance annually based on actual results.

c/ New measure in 2003.

ACHIEVING PERFORMANCE TARGETS

Protecting the Interests of Defined Benefit Plan Participants, Insurers Encouraging Risk Taking

- When a company sponsoring a defined benefit plan files for bankruptcy, PBGC becomes the advocate for the interests of the plan's participants and the pension insurance system. In 2003, PBGC fulfilled this advocacy role in 172 cases involving 676,899 participants.



- PBGC protects participant interests by monitoring companies sponsoring underfunded defined benefit plans and reviewing their corporate transactions for impact on their plan participants and the pension insurance system. In 2003, PBGC monitored 902 controlled groups involving 2,917 plans.

Customer Satisfaction

- The American Customer Satisfaction Index is the national indicator of customer satisfaction. One hundred seventy private sector companies and fifty federal agencies participate in the index, which is produced by a partnership between the University of Michigan Business School, the American Society for Quality, and the CFI Group. PBGC's 2003 index for participants in trusteed plans was 77, three points higher than the target of 74, and almost seven points higher than the federal government average of 70.2. The results identify causes and effects of satisfaction, and focus PBGC's efforts to improve three activities: customer care, concern resolution and written communications.

- PBGC's 2003 ACSI index for pension practitioners was 69, the same as in 2002. While one point below the 2003 combined index of all federal agencies, it was well above the indices for comparable federal collection programs.

Operations

- PBGC reviewed the benefit determinations issued in 2003 to verify the accuracy of its benefit calculations and issued a Statement of Reasonable Assurance of Accuracy based on the results of that review, thus meeting the goal for the year. This statement is management's confirmation that PBGC has consistently and properly applied plan formulas and actuarial factors using the best information available at the time of the calculation.

- The principal measure of operations is the average time frame needed to send benefit determinations to participants in defined benefit pension plans taken over by PBGC. PBGC's goal has been to reduce the average time frame needed to 3 years. Efforts to speed up processing

have succeeded. Plans with nearly 400,000 participants were trusteed by PBGC in 2002 and 2003, compared to the 100,000 anticipated in PBGC's original projections. In spite of this significant increase in workload, in 2003 PBGC reduced the average time it takes to get benefit determinations to participants to 2.2 years, significantly exceeding the target.

- During 2003 PBGC made trusteeship decisions within one year of opening the case for non-bankruptcy reportable events 92 percent of the time.
- Of eligible participants who completed benefit applications, 97 percent received pension payments from PBGC within three months, achieving the annual target and exceeding last year's result by two percentage points.
- In 2003, PBGC located 7,729 missing participants, some of whom might otherwise lose pension benefits they earned.

- Timeliness of PBGC's response to requests for premium refunds, waiver of penalties and reconsideration of premium decisions is a measure important to the practitioner community. The Corporation's target is ninety days from receipt to completion of the request. In 2003 PBGC met its target 82 percent of the time. This figure fell short of the 85 percent milestone set for the year but improved dramatically over the 41 percent result achieved in 2002.

- Investment management results are measured against recognized industry indices aggregated over a five-year period. PBGC realized investment returns in 2003 that were comparable to its industry indices. Returns on fixed-income securities, which represent 54 percent of the Corporation's portfolio, equaled the benchmark while equities slightly exceeded their index.

PROGRAM EVALUATION

PBGC annually evaluates the satisfaction of participants in plans trusteed by PBGC and of pension practitioners who have dealings with us on premium payment or standard termination matters. The American Customer Satisfaction Index provides the evaluations and a means to compare PBGC's results with those of other government and private organizations. Evaluation of the survey responses enables PBGC to continually improve its program operations.

FINANCIAL STATEMENTS

Management's Discussion and Analysis of Financial Condition and Results of Operations

GENERAL

The financial review that follows provides information that management believes is relevant to an assessment and understanding of the Corporation's financial condition and results of operations. The discussion should be read in conjunction with the financial statements and the accompanying notes.

PBGC's operating results are subject to significant fluctuation from year to year depending on the severity of losses from plan terminations, changes in the select interest rate, general economic conditions and other factors such as changes in law. Consequently, certain traditional financial ratios and measurements are not meaningful and, therefore, not presented.

COMBINED RESULTS

The combined programs' underwriting and financial activities resulted in a net loss of $8.019 billion. The single-employer program posted a net loss of $7.600 billion. The multiemployer program reported a net loss of $419 million, its largest to date. By law, these two programs are separate.

Investment Program: The Corporation's investable assets consist of premium revenues accounted for in the Revolving Funds and assets from terminated plans and their sponsors accounted for in the Trust Funds. By law, PBGC is required to invest the Revolving Funds in fixed-income securities; current policy is to invest these funds only in Treasury securities. PBGC has more discretion in its management of the Trust Funds, which it invests primarily in high-quality equities.

PBGC uses institutional investment management firms to invest its assets subject to PBGC oversight. Under the guidance of its Board of Directors, PBGC began a review of its investment policy to ensure that it maintains an investment structure that is consistent with its long-term objectives and responsibilities.

As of September 30, 2003, the value of PBGC's total investments in the single-employer and multiemployer programs, including cash, was approximately $34.5 billion. The Revolving Fund's value was $16.4 billion and the Trust Fund's value was $18.1 billion. Cash and fixed-income securities represented 63 percent of the total assets invested at the end of the year, compared to 72 percent at the end of 2002. Equity securities represented 37 percent of total assets invested, as compared to 28 percent at the end of 2002. A very small

portion of the invested portfolio remains in real estate and other financial instruments.

Results for fiscal year 2003 were generally positive for capital market investments and PBGC's investment program. During the year, PBGC achieved a 10.3% return on total invested funds. PBGC's fixed-income program returned 4.2% while its equity program returned 25.8%. PBGC's

INVESTMENT PERFORMANCE
(Annual Rates of Return)

	September 30, 2003	2002	Five Years Ended September 30, 2003
Total Invested Funds	10.3%	2.1%	5.0%
Equities	25.8	17.0	2.1
Fixed-Income	4.2	14.4	6.3
Trust Funds	12.8	13.5	2.4
Revolving Funds	5.6	14.4	6.5
Indices			
Wilshire 5000	26.3	17.5	2.0
S&P 500 Stock Index	25.4	-20.5	1.0
Lehman Brothers Long Treasury Index	3.7	14.5	6.5

five-year returns approximated their comparable market indices, meeting the Corporation's strategic performance goal. For the year, PBGC reported a gain of about $1.3 billion from fixed-income investments and a gain of about $2.1 billion from equity investments.

SINGLE-EMPLOYER PROGRAM

Results of Activities and Trends: The rise in business failures in more mature industries in combination with increased pension underfunding continued the trend of large claims against the pension insurance system. This resulted in a net loss in 2003 of $7.600 billion compared to the net loss of $11.370 billion in 2002. The $3.770 billion improvement was attributable to increases in investment income of $3.179 billion, premium revenue of $161 million and the net decrease in losses from completed and probable terminations ($3.936 billion). This was offset by increases in actuarial charges of $3.359 billion and administrative and other charges of $147 million.

UNDERWRITING ACTIVITY: The loss of $4.877 billion in 2003 was a significant improvement over the loss of $8.790 billion in 2002. This $3.913 billion decrease in the loss was primarily due to positive impacts from a decrease in losses from completed and probable terminations and the increase in premium revenues, offset by the increase in administrative and other charges.

Underwriting income increased from $815 million in 2002 to $976 million in 2003. The $161 million change was due primarily to the increase in variable-rate premium income triggered by the significant decrease in interest rates as well as the drop in plan asset values.

For plan years beginning in 2002 and 2003, the Required Interest Rate (RIR) used in calculating the variable-rate premium was changed to 100 percent, rather than 85 percent, of the annual yield on 30-year Treasury securities. However, the dampening effect of the RIR change on variable-rate premium revenue in 2003 was more than offset by other factors that increased plan underfunding and, therefore, variable-rate premium payments. In particular, interest rate assumptions used by plans to calculate premiums have changed since September 30, 2002. The average 30-year Treasury rate for the month of December 2001 (which was used in the calculation of 2002 premiums) was 5.48% compared to the 4.92% rate at December 2002 (which was used to calculate 2003 premiums). This was a significant change that increased plan benefit liabilities in 2003 for calendar year plans (which comprise approximately 60% of all plans). Non-calendar year plans were generally impacted in a similar manner. Consequently, variable-rate premiums increased approximately 130 percent over 2002 because of the decline in interest rate assumptions as well as any decrease in plan asset values associated with the decline in the equity markets from December 2001 to December 2002.

The Corporation's losses from completed and probable plan terminations decreased from a loss of $9.313 billion in 2002 to a loss of $5.377 billion in 2003. As in the previous year, the loss was primarily due to new plans classified as probable and the termination of underfunded pension plans. Future losses remain unpredictable as

PBGC's loss experience is highly sensitive to losses from large claims.

Administrative expenses increased $64 million over 2002, to a total of $271 million in 2003. This was primarily due to increased plan-related termination costs and increases in PBGC administrative costs.

FINANCIAL ACTIVITY: The loss from financial activity increased from $2.580 billion in 2002 to $2.723 billion in 2003. This change was primarily due to the effect of the change in interest rates on the present value of future benefits, which was partially offset by investment income.

The total return on investments was a positive 10.3% in 2003 compared to a positive 2.1% in 2002. Equity investment returns in 2003 increased by $3.946 billion over 2002 while the gain from fixed-income investments was $767 million less in 2003 than in 2002. PBGC, in accordance with accounting principles generally accepted in the United States of America (GAAP), marks its assets to market.

Actuarial charges primarily resulted from the changes in interest rates in FY 2003 and from the aging of the present value of future benefits. The PBGC select interest rate decreased from a 25-year rate of 5.70% at September 30, 2002, to a 20-year rate of 4.40% at September 30, 2003, while the ultimate rate decreased from 4.75% to 4.50%.

Liquidity and Capital Resources: The single-employer program's net position in 2003 declined significantly to a deficit of $11.238 billion primarily as a result of completed and probable terminations and actuarial charges. Of the program's total assets of $34.016 billion, $33.489 billion (98 percent) were in marketable assets.

PBGC's primary sources of cash are from premium receipts and investment activities. If funds generated from these sources are insufficient to meet operating cash needs in any period, the Corporation has available a $100 million line of credit from the U.S. Treasury for liquidity purposes. PBGC did not use this borrowing authority in 2002 or 2003 and has no plans to use it in the future. PBGC has sufficient cash flow to cover benefit payments, other operating expenses, and other liabilities for a number of years.

The total underfunding in plans (excluding probable terminations) that are sponsored by companies with below-investment-grade bond ratings, and classified by PBGC as reasonably possible, ranges from approximately $83 billion to $85 billion (see Note 7) at the December 31, 2002, measurement date. December 31st values are the most current and complete data available. Losses from these plans are not probable at this time but GAAP requires the exposure to be disclosed in the footnotes of the financial statements. This exposure was principally in air transportation; primary metals and fabricated metal products; electronic and other electrical equipment, except computer equipment; industrial and commercial machinery and computer equipment; transportation equipment; chemicals and allied products; paper and allied products; electric, gas and sanitary services; rubber and miscellaneous plastics products; and general merchandise stores.

Expected claims in the longer term are more difficult to quantify either in terms of a single number or a limited range. The amount of PBGC's future claims depends on many factors, including current underfunding among insured plans, changes in underfunding over time and bankruptcies among sponsors. These factors are influenced by future economic conditions, most particularly those affecting interest rates, investment returns and the rate of business failures. There is significant volatility in underfunding over time, as seen over the past few years.

Claims vary substantially over time reflecting overall economic conditions, the performance of some particular industries or the bankruptcy of a few very large companies. Volatility and the concentration of claims in a small number of terminations characterize PBGC expected claims.

As discussed in Note 14 of the financial statements, the Corporation is subject to litigation that could have considerable impact on its financial condition.

Benefit payments and administrative expenses are expected to exceed $3 billion in 2004. Due to significant factors

beyond PBGC's control (e.g., fluctuations in interest rates, contributions made to PBGC-insured plans by sponsors, etc.), it remains difficult to project premium receipts. PBGC's best estimate of 2004 premium receipts forecasts the amount to fall within the range of $1.0 billion to $1.1 billion.

The single-employer program's negative net position of $11.238 billion at year-end has not impacted the Corporation's ability to meet its liquidity needs and responsibilities under the Employee Retirement Income Security Act. The program's total assets of $34.016 billion assure the Corporation's ability to meet its financial obligations for a number of years.

MULTIEMPLOYER PROGRAM

Results of Activities and Trends: The 2003 multiemployer results of operations culminated in a negative net position of $261 million. The program reported a loss of $419 million in 2003 compared to a gain of $42 million in 2002. The change in net income was primarily due to the increase in the loss from future financial assistance and a decrease in investment income. The significant increase in the loss from future financial assistance resulted primarily from the reclassification of five plans as probable losses, the decrease in interest rates, and changes in plan data (e.g., updated information regarding assets, plan liabilities, contributions and withdrawal liability payments). Premium income remained stable at $25 million. Of the program's assets, PBGC invested 97.5 percent in Treasury securities in 2003 and 98.4 percent in 2002.

Liquidity and Capital Resources: Despite the multiemployer program having a negative net position, PBGC has sufficient resources to meet its liquidity requirements as most assets are highly liquid Treasury securities. In 2004, premium receipts will approximate $25 million while benefit payments and financial assistance are expected to be about $12 million.

FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT STATEMENT

Management controls in effect during fiscal year 2003 provided reasonable assurance that assets were safeguarded from material loss and that transactions were executed in accordance with management's authority and with significant provisions of selected laws and regulations. Furthermore, PBGC management controls provided reasonable assurance that transactions were properly recorded, processed and summarized to permit the preparation of financial statements in accordance with accounting principles generally accepted in the United States of America and to maintain accountability for assets among funds.

PBGC did identify a fiscal year 2003 material weakness related to the methodology used in estimating multiemployer plan liabilities. The Corporation will correct this in fiscal year 2004.

Management Representation

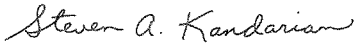
PBGC's management is responsible for the accompanying Statements of Financial Condition of the Single-Employer and Multiemployer Program Funds as of September 30, 2003 and 2002, the related Statements of Operations and Changes in Net Position and the Statements of Cash Flows for the years then ended. PBGC's management is also responsible for establishing and maintaining systems of internal accounting and administrative controls that provide reasonable assurance that the control objectives, i.e., preparing reliable financial statements, safeguarding assets and complying with laws and regulations, are achieved.

In the opinion of management, the financial statements of the Single-Employer and Multiemployer Program Funds present fairly the financial position of PBGC at September 30, 2003, and September 30, 2002, and the results of their operations and cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America (GAAP) and actuarial standards applied on a consistent basis.

Estimates of probable terminations, nonrecoverable future financial assistance, amounts due from employers and the present value of future benefits may have a material effect on the financial results being reported. Litigation has been properly disclosed and reported in accordance with GAAP.

As a result of the aforementioned, PBGC has based these statements, in part, upon informed judgments and estimates for those transactions not yet complete or for which the ultimate effects cannot be precisely measured, or for those that are subject to the effects of any pending litigation.

The Inspector General engaged Pricewaterhouse Coopers LLP (PwC) to conduct the audit of the Corporation's 2003 and 2002 financial statements. PwC issued an unqualified opinion on PBGC's September 30, 2003 and 2002, financial statements.



Steven A. Kandarian
Executive Director

Hazel Broadnax
Deputy Executive Director
and Chief Financial Officer

December 22, 2003

Pension Benefit Guaranty Corporation
Statements of Financial Condition

	Single-Employer Program		Multiemployer Program		Memorandum Total	
	September 30,		September 30,		September 30,	
(Dollars in millions)	**2003**	2002	**2003**	2002	**2003**	2002
ASSETS						
Cash and cash equivalents	**$ 3,172**	$ 716	**$ 8**	$ 3	**$ 3,180**	$ 719
Investments, at market (Note 3):						
Fixed maturity securities	**17,250**	16,742	**975**	929	**18,225**	17,671
Equity securities	**12,641**	7,349	**1**	1	**12,642**	7,350
Real estate and real estate investment trusts	**93**	38	**0**	0	**93**	38
Other	**59**	6	**0**	0	**59**	6
Total investments	**30,043**	24,135	**976**	930	**31,019**	25,065
Receivables, net:						
Sponsors of terminated plans	**132**	209	**0**	0	**132**	209
Premiums (Note 9)	**254**	121	**0**	0	**254**	121
Sale of securities	**134**	45	**0**	0	**134**	45
Investment income	**274**	197	**16**	11	**290**	208
Other	**3**	3	**0**	0	**3**	3
Total receivables	**797**	575	**16**	11	**813**	586
Furniture and fixtures, net	**4**	4	**0**	0	**4**	4
Total assets	**$34,016**	$25,430	**$1,000**	$944	**$35,016**	$26,374

The accompanying notes are an integral part of these financial statements.

Pension Benefit Guaranty Corporation
Statements of Financial Condition

	Single-Employer Program		Multiemployer Program		Memorandum Total	
	September 30,		September 30,		September 30,	
(Dollars in millions)	**2003**	2002	**2003**	2002	**2003**	2002
LIABILITIES						
Present value of future benefits, net (Note 4):						
Trusteed plans	**$ 38,945**	$21,660	**$ 3**	$ 3	**$ 38,948**	$21,663
Terminated plans pending trusteeship	**463**	476	**0**	0	**463**	476
Settlements and judgments	**67**	161	**0**	0	**67**	161
Claims for probable terminations	**5,166**	6,322	**0**	0	**5,166**	6,322
Total present value of future benefits, net	**44,641**	28,619	**3**	3	**44,644**	28,622
Present value of nonrecoverable future financial assistance (Note 5)			**1,250**	775	**1,250**	775
Unearned premiums (Note 9)	**207**	193	**8**	8	**215**	201
Due for purchases of securities	**127**	83	**0**	0	**127**	83
Accounts payable and accrued expenses (Note 6)	**279**	173	**0**	0	**279**	173
Total liabilities	**45,254**	29,068	**1,261**	786	**46,515**	29,854
Net position	**(11,238)**	(3,638)	**(261)**	158	**(11,499)**	(3,480)
Total liabilities and net position	**$ 34,016**	$25,430	**$1,000**	$944	**$ 35,016**	$26,374

The accompanying notes are an integral part of these financial statements.

Commitments and contingencies
(Notes 7, 8, 14 and 15)

Pension Benefit Guaranty Corporation
Statements of Operations and Changes in Net Position

	Single-Employer Program		Multiemployer Program		Memorandum Total	
	For the Years Ended September 30,		For the Years Ended September 30,		For the Years Ended September 30,	
(Dollars in millions)	**2003**	2002	**2003**	2002	**2003**	2002
UNDERWRITING:						
Income:						
Premium (Note 9)	**$ 948**	$ 787	**$ 25**	$ 25	**$ 973**	$ 812
Other	**28**	28	**0**	0	**28**	28
Total	**976**	815	**25**	25	**1,001**	840
Expenses:						
Administrative	**271**	207	**0**	0	**271**	207
Other	**97**	15	**0**	0	**97**	15
Total	**368**	222	**0**	0	**368**	222
Other underwriting activity:						
Losses from completed and probable terminations (Note 10)	**5,377**	9,313	**0**	0	**5,377**	9,313
Losses from financial assistance (Note 5)			**480**	101	**480**	101
Actuarial adjustments (Note 4)	**108**	70	**1**	0	**109**	70
Total	**5,485**	9,383	**481**	101	**5,966**	9,484
Underwriting loss	**(4,877)**	(8,790)	**(456)**	(76)	**(5,333)**	(8,866)
FINANCIAL:						
Investment income (loss) (Note 11):						
Fixed	**1,276**	2,043	**37**	118	**1,313**	2,161
Equity	**2,059**	(1,887)	**0**	0	**2,059**	(1,887)
Other	**14**	14	**0**	0	**14**	14
Total	**3,349**	170	**37**	118	**3,386**	288
Expenses:						
Investment	**19**	18	**0**	0	**19**	18
Actuarial charges (Note 4):						
Due to passage of time	**1,770**	1,077	**0**	0	**1,770**	1,077
Due to change in interest rates	**4,283**	1,655	**0**	0	**4,283**	1,655
Total	**6,072**	2,750	**0**	0	**6,072**	2,750
Financial income (loss)	**(2,723)**	(2,580)	**37**	118	**(2,686)**	(2,462)
Net income (loss)	**(7,600)**	(11,370)	**(419)**	42	**(8,019)**	(11,328)
Net position, beginning of year	**(3,638)**	7,732	**158**	116	**(3,480)**	7,848
Net position, end of year	**$(11,238)**	$ (3,638)	**$ (261)**	$158	**$(11,499)**	$ (3,480)

The accompanying notes are an integral part of these financial statements.

Pension Benefit Guaranty Corporation
Statements of Cash Flows

(Dollars in millions)	Single-Employer Program For the Years Ended September 30, 2003	2002	Multiemployer Program For the Years Ended September 30, 2003	2002	Memorandum Total For the Years Ended September 30, 2003	2002
OPERATING ACTIVITIES:						
Premium receipts	**$ 828**	$ 819	**$ 25**	$ 26	**$ 853**	$ 845
Interest and dividends received, net	**962**	964	**50**	50	**1,012**	1,014
Cash received from plans upon trusteeship	**360**	662	**0**	0	**360**	662
Receipts from sponsors/non-sponsors	**128**	367	**0**	0	**128**	367
Receipts from the missing participant program	**3**	9	**0**	0	**3**	9
Other receipts	**1**	4	**0**	0	**1**	4
Benefit payments - trusteed plans	**(2,154)**	(1,482)	**(1)**	(1)	**(2,155)**	(1,483)
Financial assistance payments			**(5)**	(5)	**(5)**	(5)
Settlements and judgments	**(90)**	(393)	**0**	0	**(90)**	(393)
Payments for administrative and other expenses	**(250)**	(216)	**0**	0	**(250)**	(216)
Net cash provided (used) by operating activities (Note 13)	**(212)**	734	**69**	70	**(143)**	804
INVESTING ACTIVITIES:						
Proceeds from sales of investments	**36,556**	23,207	**1,704**	643	**38,260**	23,850
Payments for purchases of investments	**(33,888)**	(24,001)	**(1,768)**	(727)	**(35,656)**	(24,728)
Net cash provided (used) by investing activities	**2,668**	(794)	**(64)**	(84)	**2,604**	(878)
Net increase (decrease) in cash and cash equivalents	**2,456**	(60)	**5**	(14)	**2,461**	(74)
Cash and cash equivalents, beginning of year	**716**	776	**3**	17	**719**	793
Cash and cash equivalents, end of year	**$ 3,172**	$ 716	**$ 8**	$ 3	**$ 3,180**	$ 719

The accompanying notes are an integral part of these financial statements.

Notes to Financial Statements
September 30, 2003 and 2002

NOTE 1—ORGANIZATION AND PURPOSE

The Pension Benefit Guaranty Corporation (PBGC or the Corporation) is a federal corporation created by Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) and is subject to the provisions of the Government Corporation Control Act. Its activities are defined in ERISA as amended by the Multiemployer Pension Plan Amendments Act of 1980, the Single-Employer Pension Plan Amendments Act of 1986, the Pension Protection Act of 1987, the Retirement Protection Act of 1994 and the Consolidated Appropriations Act, 2001. The Corporation insures pensions, within statutory limits, of participants in covered single-employer and multiemployer defined benefit pension plans that meet the criteria specified in Section 4021 of ERISA.

ERISA requires that PBGC programs be self-financing. The Corporation finances its operations through premiums collected from covered plans, assets assumed from terminated plans, collection of employer liability payments due under ERISA as amended and investment income. In addition, PBGC may borrow up to $100 million from the U.S. Treasury to finance its operations. The Corporation did not use this borrowing authority during the years ended September 30, 2003, or September 30, 2002, nor is use of this authority currently planned.

ERISA provides that the U.S. Government is not liable for any obligation or liability incurred by PBGC. As of September 30, 2003, the single-employer and multiemployer funds reported deficits of $11.238 billion and $261 million, respectively. PBGC's operating results are subject to significant fluctuation from year to year depending on the severity of losses from plan terminations, changes in the select interest rate, general economic conditions and other factors such as changes in law. PBGC estimates that the total underfunding in single-employer plans exceeded $350 billion (unaudited), and in multiemployer plans approximated $100 billion (unaudited), as of September 30, 2003. PBGC's exposure to loss is less than these amounts because of the statutory limits of insured pensions. As disclosed in Note 7, the total underfunding in single-employer plans classified by PBGC as reasonably possible of termination as of September 30, 2003, was $85 billion. PBGC also estimates that, as of September 30, 2003, it is reasonably possible that multiemployer plans may require future financial assistance in the amount of $63 million.

Neither program at present has the resources to fully satisfy PBGC's long-term obligations to plan participants. However, the single-employer program's $34 billion in assets, and the multiemployer program's $1 billion in assets, provide PBGC with sufficient liquidity to pay benefits for a number of years.

Under the single-employer program, PBGC is liable for the payment of guaranteed benefits with respect only to underfunded terminated plans. An underfunded plan may terminate only if PBGC or a bankruptcy court finds that one of the four conditions for a distress termination, as defined in ERISA, is met or if PBGC involuntarily terminates a plan under one of five specified statutory tests. The net liability assumed by PBGC is generally equal to the present value of the future benefits (including amounts owed under Section 4022(c) of ERISA) less (1) the amounts that are provided by the plan's assets and (2) the amounts that are recoverable by PBGC from the plan sponsor and members of the plan sponsor's controlled group, as defined by ERISA.

Under the multiemployer program, if a plan becomes insolvent, it receives financial assistance from PBGC to allow the plan to continue to pay participants their guaranteed benefits. PBGC recognizes assistance as a loss to the extent that the plan is not expected to be able to repay these amounts from future plan contributions, employer withdrawal liability or investment earnings.

NOTE 2—SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation: The accompanying financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP). The preparation of the financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Estimates and assumptions may change over time as new information is obtained or subsequent developments occur. Actual results could differ from those estimates.

Valuation Method: A primary objective of PBGC's financial statements is to provide information that is useful in assessing PBGC's present and future ability to ensure that defined benefit pension plan beneficiaries receive benefits when due. Accordingly, PBGC values its financial assets at estimated fair value, consistent with the standards for pension plans contained in Statement of Financial Accounting Standards"(FAS) No. 35 ("Accounting and Reporting by Defined Benefit Pension Plans"). PBGC values its liabilities for the present value of future benefits and present value of nonrecoverable future financial assistance at their estimated cost of settlement using the measurement principles of FAS No. 87 ("Employers' Accounting for Pensions").

Revolving and Trust Funds: PBGC accounts for its single-employer and multiemployer programs' revolving and trust funds on an accrual basis. Each fund is charged its portion of the benefits paid each year. PBGC has combined the revolving and trust funds for presentation purposes in the financial statements. The single-employer and multiemployer programs are separate programs by law and, therefore, PBGC reports them separately.

ERISA provides for the establishment of revolving funds that are to be used by PBGC in carrying out its duties. The revolving funds support the operational and administrative functions of PBGC and fund any deficits incurred

by PBGC in trusteeing plans or providing financial assistance. Premiums collected from ongoing plans are accounted for through the revolving funds. The Pension Protection Act of 1987 created a single-employer revolving fund that is credited with all premiums in excess of $8.50 per participant, including all penalties and interest charged on these amounts, and its share of earnings from investments. This fund may not be used to pay PBGC's administrative costs or the benefits of any plan terminated prior to October 1, 1988, unless no other amounts are available.

The trust funds reflect accounting activity associated with: (1) trusteed plans—plans for which PBGC has legal responsibility, (2) plans pending trusteeship—terminated plans for which PBGC has not become legal trustee by fiscal year-end, and (3) probable terminations—plans that PBGC determines are likely to terminate and be trusteed by PBGC. PBGC cannot exercise legal control over a plan's assets until it becomes trustee.

Allocation of Revolving and Trust Funds: PBGC allocates assets, liabilities, income and expenses to each program's revolving and trust funds to the extent that such amounts are not directly attributable to a specific fund. Revolving fund investment income is allocated on the basis of each program's average cash and investments available during the year while the expenses are allocated on the basis of each program's present value of future benefits. Revolving fund assets and liabilities are allocated on the basis of the year-end equity of each program's revolving funds. The plan assets acquired by PBGC and commingled at PBGC's custodian bank are credited directly to the appropriate fund while the earnings and expenses on the commingled assets are allocated to each program's trust funds on the basis of each trust fund's value, relative to the total value of the commingled fund.

Cash and Cash Equivalents: Cash includes cash on hand and demand deposits. Cash equivalents are securities with a maturity of one business day.

Investment Valuation and Income: PBGC bases market values on the last sale of a listed security, on the mean of the "bid-and-asked" for nonlisted securities or on a valuation model in the case of fixed-income securities that are not actively traded. These valuations are determined as of the end of each fiscal year. Purchases and sales of securities are recorded on the trade date. In addition, PBGC invests in and discloses its derivative investments in accordance with the guidance contained in FAS No. 133 ("Accounting for Derivative Instruments and Hedging Activities"). Investment income is accrued as earned. Dividend income is recorded on the ex-dividend date. Realized gains and losses on sales of investments are calculated using first in first out for the revolving fund and average cost for the trust fund. PBGC marks the plan's assets to market and any increase or decrease in the market value of a plan's assets occurring after the date on which the plan is terminated must, by law, be credited to or suffered by PBGC (see Notes 3, 4, and 11).

Sponsors of Terminated Plans, Receivables: The amounts due from sponsors of terminated plans or members of their controlled group represent the settled claims for employer liability (underfunding as of date of plan termination) and for contributions due their plan less an allowance for uncollectible amounts. PBGC discounts any amounts expected to be received beyond one year for time and risk factors. Some agreements between PBGC and plan sponsors provide for contingent payments based on future profits of the sponsors. The Corporation will report any such future amounts in the period they are realizable. Income and expenses related to amounts due from sponsors are reported in the underwriting section of the Statements of Operations and Changes in Net Position. Interest earned on settled claims for employer liability and due and unpaid employer contributions (DUEC) is reported as "Income: Other." The change in the allowances for uncollectible employer liability and DUEC is reported as "Expenses: Other."

Premiums: Premiums receivable represent the estimated earned but unpaid portion of the premiums for plans that have a plan year commencing before the end of PBGC's fiscal year and past due premiums deemed collectible, including collectible penalties and interest. The liability for unearned premiums represents an estimate of payments received during the fiscal year that cover the portion of a plan's year after PBGC's fiscal year-end. Premium income represents actual and estimated revenue generated from self-assessments from defined benefit pension plans as required by Title IV of ERISA (see Note 9).

Present Value of Future Benefits (PVFB): The PVFB is the estimated liability for future pension benefits that PBGC is or will be obligated to pay the participants of trusteed plans and terminated plans pending trusteeship. This liability is stated as the actuarial present value of estimated future benefits less the present value of estimated recoveries from sponsors and members of their controlled group and the assets of terminated plans pending trusteeship. PBGC also includes the estimated liabilities attributable to probable future plan terminations as a separate line item in the PVFB (net of estimated recoveries and assets). To measure the actuarial present value, PBGC uses assumptions to adjust the value of those future payments to reflect the time value of money (by discounting) and the probability of payment (by means of decrements, such as for death or retirement). PBGC also includes anticipated expenses to settle the benefit obligation in the determination of the PVFB. PBGC's benefit payments to participants represent a reduction to the PVFB liability.

The values of the PVFB are particularly sensitive to changes in underlying estimates and assumptions. It is likely that these estimates and assumptions will change in the near term and the impact of these changes may be material to PBGC's financial statements (see Note 4).

(1) Trusteed Plans—represents the present value of future benefit payments less the present value of expected recoveries (for which a settlement agreement has not been reached with sponsors and members of their controlled group) for plans that have terminated and been trusteed by PBGC prior to fiscal year-end.

(2) Terminated Plans Pending Trusteeship—represents the present value of future benefit payments less the plans' net assets (at fair value) anticipated to be received and the present value of expected recoveries (for which a settlement agreement has not

been reached with sponsors and members of their controlled group) for plans that have terminated but have not been trusteed by PBGC prior to fiscal year-end.

(3) Settlements and Judgments—represents estimated liabilities related to settled litigation.

(4) Net Claims for Probable Terminations—represents PBGC's best estimate of the losses, net of plan assets and the present value of expected recoveries (from sponsors and members of their controlled group) for plans that are likely to terminate in a future year. These estimated losses are based on conditions that existed as of PBGC's fiscal year-end. Management believes it is likely that one or more events subsequent to PBGC's fiscal year-end will occur, confirming the loss. Criteria used for classifying a plan as probable include: the plan sponsor is in chapter 11 liquidation or comparable state insolvency proceeding with no known solvent controlled group member; sponsor files for distress plan termination; or PBGC seeks involuntary plan termination.

In addition, PBGC provides a reserve for probable losses for plans not specifically identified and for plans with estimated underfunding less than $5 million. The reserve for unidentified losses is based on PBGC's historical experience (see Note 4).

(5) In accordance with Statement of Financial Accounting Standards No. 5, PBGC's exposure to losses from plans of companies that are classified as reasonably possible is disclosed in the footnotes. Criteria used for classifying a company as reasonably possible include: the plan sponsor in Chapter 11 reorganization; funding waiver pending or outstanding with the Internal Revenue Service (IRS); minimum funding contribution missed; below-investment-grade bond rating for Standard & Poor's (BB+) or Moody's (Ba1); no bond rating but unsecured debt below investment grade; or no bond rating but the ratio of long-term debt plus unfunded benefit liability to market value of shares is 1.5 or greater (see Note 7).

(6) In addition, PBGC identifies certain plans as high risk if the plan sponsor meets the following criteria: the company is currently in Chapter 11 proceedings; has received a minimum funding waiver within the past five years; has granted security to an unsecured creditor as part of a renegotiation of debt within the past two years; is known to have been in default on existing debt within the past two years (regardless of whether it received a waiver of default); the company's unsecured debt is now rated CCC+/Caa1 or lower by S&P or Moody's, respectively; or any other set of circumstances that in the analyst's judgment constitutes a high risk situation.

PBGC specifically reviews each plan identified as high risk and classifies those plans as probable if, based on available evidence, PBGC concludes that plan termination is likely. Otherwise, high risk plans are classified as reasonably possible.

Present Value of Nonrecoverable Future Financial Assistance: In accordance with Title IV of ERISA, PBGC provides financial assistance to multiemployer plans, in the form of loans, to enable the plans to pay guaranteed benefits to participants and reasonable administrative expenses. These loans, issued in exchange for interest-bearing promissory notes, constitute an obligation of each plan.

The present value of nonrecoverable future financial assistance represents the estimated nonrecoverable payments to be provided by PBGC in the future to multiemployer plans that will not be able to meet their benefit obligations. The present value of nonrecoverable future financial assistance is based on the difference between the present value of future guaranteed benefits and expenses and the market value of plan assets, including the present value of future amounts expected to be paid by employers, for those plans that are expected to require future assistance. The amount reflects the rates at which, in the opinion of management, these liabilities (net of expenses) could be settled in the market for single-premium nonparticipating group annuities issued by private insurers (see Note 5).

A liability for a particular plan is included in the Present Value of Nonrecoverable Future Financial Assistance when it is determined that the plan is insolvent and will require assistance to pay the participants their guaranteed benefit. Determining insolvency requires considering several complex factors, such as an estimate of future cash flows, future mortality rates, and age of participants not in pay status.

Other Expenses: These expenses represent a current period estimate of the net amount of receivables deemed to be uncollectible. The estimate is based on the most recent status of the debtor (e.g., sponsor), the age of the receivables and other factors that indicate the element of uncollectibility in the receivables outstanding.

Losses from Completed and Probable Terminations: Amounts reported as losses from completed and probable terminations represent the difference as of the actual or expected date of plan termination between the present value of future benefits (including amounts owed under Section 4022(c) of ERISA) assumed, or expected to be assumed, by PBGC, less related plan assets and the present value of expected recoveries from sponsors and members of their controlled group (see Note 10). In addition, the plan's net income from date of plan termination to the beginning of the fiscal year is included as a component of losses from completed and probable terminations for plans with termination dates prior to the year in which they were added to PBGC's inventory of terminated plans.

Actuarial Adjustments and Charges (Credits): PBGC classifies actuarial adjustments related to changes in method and the effect of experience as underwriting activity; actuarial adjustments are the result of the movement of plans from one valuation methodology to another (e.g., nonseriatim to seriatim) and of new data (e.g., deaths, revised participant data). Actuarial charges (credits) related to changes in interest rates and passage of time are classified as financial activity. These adjustments and charges (credits) represent the change in the

PVFB that results from applying actuarial assumptions in the calculation of future benefit liabilities (see Note 4).

Depreciation: PBGC calculates depreciation of its furniture and equipment on a straight-line basis over the estimated useful lives of the assets. The useful lives range from 5 to 10 years. Routine maintenance and leasehold improvements (the amounts of which are not material) are charged to operations as incurred.

NOTE 3—INVESTMENTS

Premium receipts are invested in securities issued by the U.S. Government.

The trust funds include assets PBGC acquires or expects to acquire with respect to terminated plans and investment income thereon. These assets generally are held by custodian banks. The basis and market value of the investments by type are detailed below. The basis indicated is cost of the asset if acquired after the date of plan termination or the market value at date of plan termination if the asset was acquired as a result of a plan's termination. PBGC marks the plan's assets to market and any increase or decrease in the market value of a plan's assets occurring after the date on which the plan is terminated must, by law, be credited to or suffered by PBGC. Note 11 provides the components of investment income.

INVESTMENTS OF SINGLE-EMPLOYER REVOLVING FUNDS AND SINGLE-EMPLOYER TRUSTEED PLANS

	September 30, 2003		September 30, 2002	
(Dollars in millions)	**Basis**	**Market Value**	Basis	Market Value
Fixed maturity securities:				
U.S. Government securities	**$14,997**	**$15,450**	$14,165	$15,796
Commercial paper	**87**	**87**	28	28
Asset backed securities	**937**	**942**	440	447
Corporate and other bonds	**740**	**771**	478	471
Subtotal	**16,761**	**17,250**	15,111	16,742
Equity securities	**10,040**	**12,641**	6,847	7,349
Real estate and real estate investment trusts	**97**	**93**	42	38
Insurance contracts and other investments	**74**	**59**	15	6
Total *	**$26,972**	**$30,043**	$22,015	$24,135

* This includes securities on loan at September 30, 2003, and September 30, 2002, with a market value of $213 million and $122 million, respectively.

INVESTMENTS OF MULTIEMPLOYER REVOLVING FUNDS AND MULTIEMPLOYER TRUSTEED PLANS

	September 30, 2003		September 30, 2002	
(Dollars in millions)	**Basis**	**Market Value**	Basis	Market Value
Fixed maturity securities:				
U.S. Government securities	**$946**	**$975**	$832	$929
Equity securities	**1**	**1**	1	1
Total	**$947**	**$976**	$833	$930

Derivative Investments: Derivatives are accounted for at market value in accordance with Statement of Financial Accounting Standards No. 133, as amended. Derivatives are marked to market with changes in value reported within financial income. During fiscal years 2002 and 2003, PBGC invested in an investment product that contained Standard & Poor's (S&P) 500 financial futures contracts. The objective of this investment strategy is to exceed, net of fees, the total rate of return of the S&P 500 Index while maintaining a very similar risk level to that of the index. S&P 500 Index futures are used to obtain cost-effective equity exposure for implementing the strategy. Beginning September 24, 2003, PBGC invested in an investment product that contained U.S. government bond futures and a swaption contract. The objective of this investment strategy is to exceed, net of fees, the total rate of return of a customized benchmark for a long duration fixed income mandate. This benchmark proxies the expected behavior of PBGC's liabilities and reflects the objective of mitigating interest rate sensitivity. Government bond futures are held to adjust interest rate exposure (duration). Swaptions are held (or sold) to adjust interest rate exposure (duration) and to generate income to reflect the investment views of the portfolio managers regarding relationships between interest rates. At September 30, 2003, PBGC had one written swaption with a notional amount of $59,000,000. In 2002 and 2003, PBGC also invested in an investment product that contained U.S. and non-U.S. stock index futures contracts, U.S. and non-U.S. government bond futures and forward contracts, U.S. stock warrants, non-U.S. government debt option contracts and foreign currency forward and option contracts. The objective of this investment strategy is to exceed, net of fees, the total rate of return of a customized benchmark for a global balanced mandate while maintaining a very similar risk level to that benchmark. Stock index futures contracts are held to affect asset allocation and country equity exposure. Government bond futures and forward contracts are held to affect sector asset allocation and to adjust interest rate (duration) and country exposure. U.S. stock warrants are held as a result of a corporate action. Non-U.S. government debt option contracts are held to reflect the investment views of the portfolio managers regarding government debt issues. Foreign currency forward and option contracts are held to hedge currency exposure (i.e., minimize currency risk) of certain assets and to adjust overall currency exposure to reflect the investment views of the portfolio managers regarding relationships between currencies. PBGC is accomplishing these objectives typically, but not exclusively, by holding long and short positions in stock index futures, government bond futures, foreign currency forward contracts

and other derivative instruments. The counterparties to PBGC's foreign currency exchange contracts are major financial institutions. PBGC has never experienced non-performance by any of its counterparties.

In addition to the initial margin of generally 1 to 6 percent maintained with the broker in Treasury bills or similar instruments, financial futures contracts require daily settlement of variation margin. For the fiscal years ended September 30, 2003, and September 30, 2002, gains and losses from settled margin calls are reported in Investment income on the Statements of Operations and Changes in Net Position. The fair value of the derivative instruments (the amount needed to settle at September 30) reported on the Statements of Financial Condition as part of "Sale of securities" was $2 million at September 30, 2003, as compared to less than $1 million at September 30, 2002, and $7 million as part of "Due for purchases of securities" at September 30, 2003, as compared to $6 million at September 30, 2002.

Fair Value of Financial Instruments

	Notional Value at September 30,		Fair Value at September 30,	
(Dollars in millions)	**2003**	2002	**2003**	2002
Financial futures contracts	**$662**	$264	**$(393)**	$(335)
Open currency forward contracts				
U.S. Dollar long/short foreign currencies	**132**	136	**135**	136
U.S. Dollar short/long foreign currencies	**135**	106	**139**	106

Financial futures contracts are traded on organized exchanges and thus bear minimal credit risk. The exchange clears, settles and guarantees transactions occurring through its facilities. Institutional investors hold these futures contracts on behalf of PBGC and mark to market daily. In periods of extreme volatility, margin calls may create a high liquidity demand on the underlying portfolio. To mitigate this, PBGC maintains adequate liquidity in its portfolio to meet these margin calls.

Security Lending: PBGC participates in a security lending program administered by its custodian bank. The custodian bank requires collateral that equals 102 percent to 105 percent of the securities lent. The collateral is held by the custodian bank. In addition to the lending program managed by the custodian bank, some of PBGC's investment managers are authorized to invest in repurchase agreements and reverse repurchase agreements. The manager either receives cash as collateral or pays cash out to be used as collateral. Any cash collateral received is invested. The total value of securities on loan at September 30, 2003, and September 30, 2002, was $213 million and $122 million, respectively.

NOTE 4—PRESENT VALUE OF FUTURE BENEFITS

The following table summarizes the actuarial adjustments, charges and credits that explain how the Corporation's single-employer program liability for the present value of future benefits changed for the years ended September 30, 2003 and 2002.

For FY 2003, PBGC used a 20-year select interest rate of 4.40% followed by an ultimate rate of 4.50% for the remaining years and for FY 2002, a 25-year select interest rate of 5.70% followed by an ultimate rate of 4.75% for the remaining years. These rates were determined to be those needed to continue to match the survey of annuity prices provided by the American Council of Life Insurers. PBGC's regulations state that both the interest rate and the length of the select period may vary to produce the best fit with these prices. The prices reflect rates at which, in the opinion of management, the liabilities (net of expenses) could be settled in the market at September 30, for the respective year, for single-premium nonparticipating group annuities issued by private insurers. Many factors, including Federal Reserve policy, may impact these rates.

For September 30, 2003, PBGC used the 1994 Group Annuity Mortality (GAM) Static Table (with margins), set forward two years and projected 18 years to 2012 using Scale AA. For September 30, 2002, PBGC used the same table, set forward two years but projected 16 years to 2010 using Scale AA. The number of years that PBGC projects the mortality table reflects the number of years from the 1994 base year of the table to the end of the fiscal year (9 years in 2003 versus 8 years in 2002) plus PBGC's calculated duration of its liabilities (9 years in 2003 versus 8 years in 2002). PBGC's procedure is based on the procedures recommended by the Society of Actuaries UP-94 Task Force (which developed the GAM94 table) for taking into account future mortality improvements.

The reserve for administrative expenses in the 2003 and 2002 valuation was assumed to be 1.18 percent of benefit liabilities plus additional reserves for cases whose plan asset determinations, participant database audits and actuarial valuations were not yet complete. The expense assumption was based on a study performed for PBGC in 2000 by a major accounting firm. The factors to determine the additional reserves were based on case size, number of participants and time since trusteeship.

The present values of future benefits for trusteed multiemployer plans for 2003 and 2002 reflect the payment of benefits and the changes in interest assumptions, passage of time and the effect of experience.

The resulting liability represents PBGC's best estimate of the measure of anticipated experience under these programs.

RECONCILIATION OF THE PRESENT VALUE OF FUTURE BENEFITS FOR THE YEARS ENDED SEPTEMBER 30, 2003 AND 2002

(Dollars in millions)	September 30, 2003		2002	
Present value of future benefits, at beginning of year—Single-Employer, net		**$28,619**		$13,497
Estimated recoveries, prior year		**38**		19
Assets of terminated plans pending trusteeship, net, prior year		**323**		577
Present value of future benefits at beginning of year, gross		**28,980**		14,093
Settlements and judgments, prior year		**(161)**		(177)
Net claims for probable terminations, prior year		**(6,322)**		(411)
Actuarial adjustments—underwriting:				
Changes in method and assumptions	**$ 21**		$ (67)	
Effect of experience	**87**		137	
Total actuarial adjustments—underwriting	**108**		70	
Actuarial charges—financial:				
Passage of time	**1,770**		1,077	
Change in interest rates	**4,283**		1,655	
Total actuarial charges—financial	**6,053**		2,732	
Total actuarial charges, current year		**6,161**		2,802
Terminations:				
Current year	**13,431**		7,704	
Changes in prior year	**47**		23	
Total terminations		**13,478**		7,727
Benefit payments, current year*		**(2,488)**		(1,537)
Estimated recoveries, current year		**(68)**		(38)
Assets of terminated plans pending trusteeship, net, current year		**(172)**		(323)
Settlements and judgments, current year		**67**		161
Net claims for probable terminations:				
Future benefits**	**9,694**		12,392	
Estimated plan assets and recoveries from sponsors	**(4,528)**		(6,070)	
Total net claims, current year		**5,166**		6,322
Present value of future benefits, at end of year—Single-Employer, net		**44,641**		28,619
Present value of future benefits, at end of year—Multiemployer		**3**		3
Total present value of future benefits, at end of year, net		**$44,644**		$28,622

* The benefit payments of $2,488 million and $1,537 million include $334 million in 2003 and $55 million in 2002 for benefits paid from plan assets by plans prior to trusteeship.

** The future benefits for probable terminations of $9,694 million and $12,392 million for fiscal years 2003 and 2002, respectively, include $173 million and $70 million, respectively, in net claims (future benefits less estimated plan assets and recoveries) for probable terminations not specifically identified and $9,521 million and $12,322 million, respectively, in net claims for specifically identified probables.

The following table details the assets that make up single-employer terminated plans pending trusteeship:

ASSETS OF SINGLE-EMPLOYER TERMINATED PLANS PENDING TRUSTEESHIP, NET

	September 30, 2003		September 30, 2002	
(Dollars in millions)	**Basis**	**Market Value**	Basis	Market Value
Corporate and other bonds	**$ 84**	**$ 89**	$225	$225
Equity securities	**66**	**75**	165	86
Insurance contracts	**4**	**4**	4	4
Other	**4**	**4**	8	8
Total, net	**$158**	**$172**	$402	$323

Net Claims for Probable Terminations: Factors that are presently not fully determinable may be responsible for these claim estimates differing from actual experience. Included in net claims for probable terminations is a provision for future benefit liabilities for plans not specifically identified.

The values recorded in the following reconciliation table have been adjusted to the expected dates of termination.

RECONCILIATION OF NET CLAIMS FOR PROBABLE TERMINATIONS

	September 30,	
(Dollars in millions)	**2003**	2002
Net claims for probable terminations, at beginning of year	**$ 6,322**	$ 411
New claims	**$ 4,211**	$6,232
Actual terminations	**(5,448)**	(338)
Deleted probables	**(228)**	(1)
Change in benefit liabilities	**229**	23
Change in plan assets	**80**	(5)
Loss (credit) on probables	**(1,156)***	5,911*
Net claims for probable terminations, at end of year	**$ 5,166**	$6,322

* See Note 10

The following table itemizes the probable exposure by industry:

PROBABLES EXPOSURE BY INDUSTRY (PRINCIPAL CATEGORIES)

(Dollars in millions)	**FY 2003**	FY 2002
Primary Metals and Fabricated Metal Products	**$2,062**	$5,831
Air Transportation	**1,290**	*
Wholesale Trade - Non-Durable Goods	**372**	*
Apparel and Other Finished Products Made from Fabrics	**231**	*
Food Stores	**201**	*
Chemicals and Allied Products	**125**	*
Heavy Construction Other Than Building Construction - Contractors	**112**	*
Others	**773**	491
Total	**$5,166**	$6,322

* included in Others

The following table shows what has happened to plans classified as probables. This table does not capture or include those plans that were not initially classified as probable.

PROBABLES EXPERIENCE
AS INITIALLY RECORDED BEGINNING IN 1987

(Dollars in millions)	Status of Probables from 1987-2002 at September 30, 2003			
Beginning in 1987, number of plans reported as Probable:	Number of Plans	Percent of Plans	Net Claim	Percent of Net Claim
Probables terminated	185	75%	$ 8,707	86%
Probables current	16	6	573	6
Probables deleted	47	19	783	8
Total	248	100%	$10,063	100%

NOTE 5—MULTIEMPLOYER FINANCIAL ASSISTANCE

PBGC provides financial assistance to multiemployer defined benefit pension plans in the form of loans. An allowance is set up to the extent that repayment of these loans is not expected.

NOTES RECEIVABLE MULTIEMPLOYER FINANCIAL ASSISTANCE

	September 30,	
(Dollars in millions)	**2003**	2002
Gross balance at beginning of year	**$ 56**	$ 51
Financial assistance payments—current year	**5**	5
Subtotal	**61**	56
Allowance for uncollectible amounts	**(61)**	(56)
Net balance at end of year	**$ 0**	$ 0

The losses from financial assistance reflected in the Statements of Operations and Changes in Net Position include annual changes in the estimated present value of nonrecoverable future financial assistance and assistance granted that was not previously accrued.

PRESENT VALUE OF NONRECOVERABLE FUTURE FINANCIAL ASSISTANCE AND LOSSES FROM FINANCIAL ASSISTANCE

	September 30,	
(Dollars in millions)	**2003**	2002
Balance at beginning of year	**$ 775**	$679
Changes in allowance:		
Losses from financial assistance	**480**	101
Financial assistance granted (previously accrued)	**(5)**	(5)
Balance at end of year	**$1,250**	$775

NOTE 6—ACCOUNTS PAYABLE AND ACCRUED EXPENSES

The following table itemizes accounts payable and accrued expenses reported in the Statements of Financial Condition:

ACCOUNTS PAYABLE AND ACCRUED EXPENSES

	September 30,	
(Dollars in millions)	**2003**	2002
Annual leave	**$ 5**	$ 4
Collateral held for loaned securities	**220**	128
Other payables and accrued expenses	**54**	41
Accounts payable and accrued expenses	**$279**	$173

NOTE 7—CONTINGENCIES

There are a number of large single-employer plans that are sponsored by companies whose credit quality is below investment grade and may terminate. In addition, there are some multiemployer plans that may require future financial assistance. The amounts disclosed below represent the Corporation's best estimates given the inherent uncertainties about these plans.

In accordance with Statement of Financial Accounting Standards No. 5, PBGC classified a number of these companies as reasonably possible terminations as the sponsors' financial condition and other factors did not indicate that termination of their plans was likely as of year-end. The estimated aggregate unfunded vested benefits exposure to PBGC for the companies' single-employer plans classified as reasonably possible as of September 30, 2003, ranged from $83 to $85 billion.

The estimated unfunded vested benefits exposure has been calculated as of December 31, 2002. PBGC calculated this estimate as in previous years by using data obtained from filings and submissions with the government and from corporate annual reports for fiscal years ending in calendar 2002. The Corporation adjusted the value reported for liabilities to the December 31, 2002, PBGC select interest rate of 5.00% (the liabilities are not valued at September 30 as the information is not available). When available, data were adjusted to a consistent set of mortality assumptions. The underfunding associated with these sponsors' plans would generally tend to be greater at September 30, 2003, because of the economic conditions (e.g., lower interest rates and/or low investment returns on plan assets) that existed between December 31, 2002, and September 30, 2003. The Corporation did not adjust the estimate for events that occurred between December 31, 2002, and September 30, 2003.

The following table itemizes the reasonably possible exposure by industry:

REASONABLY POSSIBLE EXPOSURE BY INDUSTRY (PRINCIPAL CATEGORIES)

(Dollars in billions)	**FY 2003**	FY 2002
Air Transportation	**$23.4**	$11.4
Primary Metals and Fabricated Metal Products	**10.2**	5.7
Electronic and Other Electrical Equipment, except Computer Equipment	**7.0**	1.3
Industrial and Commercial Machinery and Computer Equipment	**5.3**	1.8
Transportation Equipment	**4.0**	*
Chemicals and Allied Products	**3.9**	1.4
Paper and Allied Products	**3.7**	1.2
Electric, Gas and Sanitary Services	**2.8**	*
Rubber and Miscellaneous Plastics Products	**2.7**	1.4
General Merchandise Stores	**2.5**	1.3
Others	**20.0**	9.9
Total	**$85.5**	$35.4

* included in Others

PBGC included amounts in the liability for the present value of nonrecoverable future financial assistance (see Note 5) for multiemployer plans that PBGC estimated may require future financial assistance. In addition, PBGC currently estimates that it is reasonably possible that other multiemployer plans may require future financial assistance in the amount of $63 million.

The Corporation calculated the future financial assistance liability for each multiemployer plan identified as probable or reasonably possible as the present value of guaranteed future benefit and expense payments net of any future contributions or withdrawal liability payments as of the later of September 30, 2003, or the projected (or actual, if known) date of plan insolvency, discounted back to September 30, 2003, using interest only. The Corporation's identification of plans that are likely to require such assistance and estimation of related amounts required consideration of many complex factors, such as an estimate of future cash flows, future mortality rates, and age of participants not in pay status. These factors are affected by future events, including actions by plans and their sponsors, most of which are beyond the Corporation's control.

PBGC used select and ultimate interest rate assumptions of 4.40% for the first 20 years after the valuation date and 4.50% thereafter. The Corporation also used the 1994 Group Annuity Mortality Static Table (with margins), set forward two years, projected 18 years to 2012 using Scale AA.

NOTE 8—COMMITMENTS

PBGC leases its office facility under a commitment that began on December 11, 1993, and expires December 10, 2008. The lease provides for periodic rate increases based on increases in operating costs and real estate taxes over a base amount. In addition, PBGC is leasing space for field benefit administrators. These leases began in 1996 and expire in 2010. The minimum future lease payments for office facilities having noncancellable terms in excess of one year as of September 30, 2003, are as follows:

COMMITMENTS: FUTURE LEASE PAYMENTS

(Dollars in millions)	
Years Ending September 30,	Operating Leases
2004	$15.6
2005	15.8
2006	16.2
2007	16.4
2008	16.2
Thereafter	8.3
Minimum lease payments	$88.5

Lease expenditures were $14.6 million in 2003 and $12.2 million in 2002.

NOTE 9—PREMIUMS

For both the single-employer and multiemployer programs, ERISA provides that PBGC shall continue to guarantee basic benefits despite the failure of a plan administrator to pay premiums when due. PBGC assesses interest and penalties on the unpaid or underpayment of premiums. Interest continues to accrue until the premium and the interest due are paid. The amount of penalty that can be levied is capped at 100 percent of the premium late payment or underpayment. Annual premiums for the single-employer program are $19 per participant for a fully funded plan. Underfunded single-employer plans pay an additional variable-rate charge, based on funding levels. The multiemployer premium is $2.60 per participant.

NOTE 10—LOSSES FROM COMPLETED AND PROBABLE TERMINATIONS

Amounts reported as losses are the present value of future benefits (including amounts owed under Section 4022(c)) less related plan assets and the present value of expected recoveries from sponsors. The following table details the components that make up the losses:

LOSSES FROM COMPLETED AND PROBABLE TERMINATIONS–SINGLE-EMPLOYER PROGRAM

	For the Years Ended September 30,					
	2003			2002		
(Dollars in millions)	**New Terminations**	**Changes in Prior Year Terminations**	**Total**	New Terminations	Changes in Prior Year Terminations	Total
Present value of future benefits	**$13,431**	**$ 47**	**$13,478**	$7,704	$23	$7,727
Less plan assets	**6,963**	**(79)**	**6,884**	4,664	8	4,672
Plan asset insufficiency	**6,468**	**126**	**6,594**	3,040	15	3,055
Less estimated recoveries	**61**	**(3)**	**58**	27	3	30
Subtotal	**$ 6,407**	**$129**	**6,536**	$3,013	$12	3,025
Settlements and judgments			**(3)**			377
Loss (credit) on probables			**(1,156)***			5,911*
Total			**$ 5,377**			$9,313

* See Note 4

NOTE 11—FINANCIAL INCOME

The following tables detail the combined financial income by type of investment as well as the investment profile for both the single-employer and multiemployer programs:

FINANCIAL INCOME

	For the Years Ended September 30,	
(Dollars in millions)	**2003**	2002
Fixed-income securities:		
Interest earned	**$ 941**	$ 985
Realized gain	**1,599**	315
Unrealized gain (loss)	**(1,227)**	861
Total fixed-income securities	**1,313**	2,161
Equity securities:		
Dividends earned	**75**	34
Realized loss	**(134)**	(382)
Unrealized gain (loss)	**2,118**	(1,539)
Total equity securities	**2,059**	(1,887)
Other income	**14**	14
Total financial income	**$ 3,386**	$ 288

INVESTMENT PROFILE

	September 30,	
	2003	2002
Fixed-Income Assets		
Average Quality	**AAA**	AAA
Average Maturity (years)	**17.2**	18.1
Duration (years)	**10.1**	10.3
Yield to Maturity (%)	**4.6**	4.5
Equity Assets		
Average Price/Earnings Ratio	**24.2**	24.6
Dividend Yield (%)	**1.7**	1.9
Beta	**0.96**	0.96

NOTE 12—EMPLOYEE BENEFIT PLANS

All permanent full-time and part-time PBGC employees are covered by the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Full-time and part-time employees with less than five years service under CSRS and hired after December 31, 1983, are automatically covered by both Social Security and FERS. Employees hired before January 1, 1984, participate in CSRS unless they elected and qualified to transfer to FERS.

The Corporation's contribution to the CSRS plan for the first three months of 2003 was 7.5 percent and 7.0 percent for the remainder of the year and 8.51 percent for 2002 of base pay for those employees covered by that system. For those employees covered by FERS, the Corporation's contribution was 10.7 percent of base pay for both 2003 and 2002. In addition, for FERS-covered employees, PBGC automatically contributes 1 percent of base pay to the employee's Thrift Savings account, matches the first 3 percent contributed by the employee and matches one-half of the next 2 percent contributed by the employee. Total retirement plan expenses amounted to $10 million in 2003 and $8 million in 2002.

These financial statements do not reflect CSRS or FERS assets or accumulated plan benefits applicable to PBGC employees. These amounts are reported by the U.S. Office of Personnel Management (OPM) and are not allocated to the individual employers. OPM accounts for federal health and life insurance programs for those eligible retired PBGC employees who had selected federal government-sponsored plans. PBGC does not offer other supplemental health and life insurance benefits to its employees.

NOTE 13—CASH FLOWS

The following is a reconciliation between the net income as reported in the Statements of Operations and Changes in Net Position and net cash provided by operating activities as reported in the Statements of Cash Flows.

RECONCILIATION OF NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES

	Single-Employer Program		Multiemployer Program		Memorandum Total	
	September 30,		September 30,		September 30,	
(Dollars in millions)	**2003**	2002	**2003**	2002	**2003**	2002
Net income (loss)	**$(7,600)**	$(11,370)	**$(419)**	$ 42	**$(8,019)**	$(11,328)
Adjustments to reconcile net income to net cash provided by operating activities:						
Net (appreciation) decline in fair value of investments	**(2,308)**	701	**11**	(67)	**(2,297)**	634
Net (gain) loss of terminated plans pending trusteeship	**(108)**	79	**0**	0	**(108)**	79
Losses on completed and probable terminations	**5,377**	9,313	**0**	0	**5,377**	9,313
Actuarial charges	**6,161**	2,802	**1**	0	**6,162**	2,802
Benefit payments - trusteed plans	**(2,154)**	(1,482)	**(1)**	(1)	**(2,155)**	(1,483)
Settlements and judgments	**(90)**	(393)	**0**	0	**(90)**	(393)
Cash received from plans upon trusteeship	**360**	662	**0**	0	**360**	662
Receipts from sponsors/non-sponsors	**225**	383	**0**	0	**225**	383
Amortization of discounts/premiums	**108**	(15)	**7**	0	**115**	(15)
Changes in assets and liabilities, net of effects of trusteed and pending plans:						
(Increase) decrease in receivables	**(210)**	39	**(5)**	0	**(215)**	39
Increase in present value of nonrecoverable future financial assistance			**475**	96	**475**	96
Increase in unearned premiums	**14**	2	**0**	0	**14**	2
Increase in accounts payable	**13**	13	**0**	0	**13**	13
Net cash provided (used) by operating activities	**$ (212)**	$ 734	**$ 69**	$ 70	**$ (143)**	$ 804

NOTE 14—LITIGATION

Legal challenges to PBGC policies and positions continued in 2003. At the end of the fiscal year, PBGC had 119 active cases in state and federal courts and 633 bankruptcy cases. PBGC records as a liability on its financial statements an estimated cost for unresolved litigation to the extent that losses in such cases are probable and estimable in amount. PBGC estimates that possible losses of up to $47 million could be incurred in the event that PBGC does not prevail in these matters.

NOTE 15—SUBSEQUENT EVENTS

Subsequent to September 30, 2003, business and financial conditions significantly deteriorated for some sponsors of large single-employer plans that may terminate. These plans will be added as probables or to the terminated inventory in FY 2004. Had these plan sponsor events occurred prior to FY 2003 year-end, PBGC's financial statements would have reflected an increase of $48 million in the Net loss and a decrease in the Net position in the same amount.

Subsequent to September 30, 2003, a buyer for a company whose plan is classified as probable entered into an agreement to purchase the company and assume the pension plan. This plan has been removed from probables in FY 2004. Had this occurred prior to FY 2003 year-end, PBGC's single-employer financial statements would have reflected a decrease of $125 million in the Net loss and an increase in the Net position of the same amount.

The total effect of all of the afore-mentioned subsequent events would have resulted in a decrease of $77 million in the Net loss and an increase in the Net position of the same amount.

There were no subsequent events to report on the multiemployer program.

ACTUARIAL VALUATION

PBGC calculated and validated the present value of future PBGC-payable benefits (PVFB) for both the single-employer and multiemployer programs and of nonrecoverable future financial assistance under the multiemployer program. Methods and procedures for both single-employer and multiemployer plans were generally the same as those used in 2002.

PRESENT VALUE OF FUTURE BENEFITS AND NONRECOVERABLE FINANCIAL ASSISTANCE – 2003

	Number of Plans	Number of Participants	Liability
		(in thousands)	*(in millions)*
I. SINGLE-EMPLOYER PROGRAM			
A. Terminated plans			
1. Seriatim at fiscal year-end (FYE)	2,825	345	$10,205
2. Seriatim at DOPT, adjusted to FYE	86	25	1,017
3. Nonseriatim[1]	366	446	28,454
4. Rettig Settlement (seriatim)[2]		*	1
5. Missing Participants Program (seriatim)[3]		18	38
Subtotal	3,277	834	39,715
B. Probable terminations (nonseriatim)[4]	78	198	9,694
Total[5]	3,355	1,032	$49,409
II. MULTIEMPLOYER PROGRAM			
A. Pre-MPPAA terminations (seriatim)	10	*	$ 3
B. Post-MPPAA liability (net of plan assets)	62	100	1,250
Total	72	100	$ 1,253

* Fewer than 500 participants

Notes:

1) The liability for terminated plans has been increased by $108 million for terminated plans not yet reported and for other settlements.

2) The Rettig Settlement refers to the liability that PBGC incurred due to the settlement of a class action lawsuit that increased benefits for some participants and provided new benefits to others. The remaining participants not yet paid are valued seriatim.

3) The Missing Participants Program refers to a liability that PBGC assumed for unlocated participants in standard plan terminations.

4) The net claims for probable plans reported in the financial statements include $173 million for not-yet-identified probable terminations. The assets for the probable plans, including the expected value of recoveries on employer liability and due-and-unpaid employer contributions claims, are $4,528 million. Thus, the net claims for probable terminations as reported in the financial statements are $9,694 million less $4,528 million, or $5,166 million.

5) The PVFB in the financial statements ($44,641 million) is net of estimated plan assets and recoveries on probable terminations ($4,528 million), estimated recoveries on terminated plans ($68 million), and estimated assets for plans pending trusteeship ($172 million), or, $49,409 million less $4,528 million less $68 million less $172 million = $44,641 million.

Single-Employer Program

PBGC calculated the single-employer program's liability for benefits in the terminated plans and probable terminations, as defined in Note 2 to the financial statements, using a combination of two methods: seriatim and nonseriatim. For 2,825 plans, representing about 86 percent of the total number of single-employer terminated plans (41 percent of the total participants in single-employer terminated plans), PBGC had sufficiently accurate data to calculate the liability separately for each participant's benefit — the seriatim method. This was an increase of 275 plans over the 2,550 plans valued seriatim last year. For 86 plans whose data were not yet fully automated, PBGC calculated the benefits and liability seriatim as of the date of plan termination (DOPT) and brought the total amounts forward to the end of fiscal year 2003.

For 366 other terminated plans, PBGC did not have sufficiently accurate or complete data to value individual benefits. Instead, the Corporation used a "nonseriatim" method that brought the liabilities from the plan's most recent actuarial valuation forward to the end of fiscal year 2003 using certain assumptions and adjustment factors.

For the actuarial valuation, PBGC used a select and ultimate interest rate assumption of 4.4% for the first 20 years after the valuation date and 4.5% thereafter. The mortality assumption used for valuing healthy lives was the 1994 Group Annuity Mortality Static Table (with margins), set forward two years, projected 18 years to 2012 using Scale AA. The projection period is determined as the sum of the elapsed time from the date of the table (1994) to the valuation date plus the period of time from the valuation date to the average date of payment of future benefits. PBGC assumed an explicit loading for expenses in all terminated plans and single-employer probable terminations. The reserve for expenses in the 2003 valuation was assumed to be 1.18% of the liability for benefits plus additional reserves for cases whose plan asset determinations, participant database audits, and actuarial valuations were not yet complete. The factors to determine the additional reserves were based on case size, number of participants, and time since trusteeship.

For non-pay-status participants, PBGC used expected retirement ages, as explained in subpart B of the Allocation of Assets in Single-Employer Plans regulation. PBGC assumed that participants who had attained their expected retirement age were in pay status. In seriatim plans, for participants who were older than their plan's normal retirement age, were not in pay status, and were unlocated at the valuation date, PBGC reduced the value of their future benefits to zero over the three years succeeding normal retirement age to reflect the lower likelihood of payment.

Multiemployer Program

PBGC calculated the liability for the 10 pre-MPPAA terminations using the same assumptions and methods applied to the single-employer program.

PBGC based its valuation of the post-MPPAA liability for nonrecoverable future financial assistance on the most recent available actuarial reports, Form 5500 Schedule B's, and information provided by representatives of the affected plans. The Corporation expected 62 plans to need financial assistance because severe industrial declines have left them with inadequate contribution bases and they had insufficient assets for current payments or were expected to run out of assets in the foreseeable future.

Statement of Actuarial Opinion

This valuation has been prepared in accordance with generally accepted actuarial principles and practices and, to the best of my knowledge, fairly reflects the actuarial present value of the Corporation's liabilities for the single-employer and multiemployer plan insurance programs as of September 30, 2003.

In preparing this valuation, I have relied upon information provided to me regarding plan provisions, plan participants, plan assets, and other matters, some of which are detailed in a complete Actuarial Report available from PBGC.

In my opinion, (1) the techniques and methodology used for valuing these liabilities are generally acceptable within the actuarial profession; (2) the assumptions used are appropriate for the purposes of this statement and are individually my best estimate of expected future experience discounted using current settlement rates from insurance companies; and (3) the resulting total liability represents my best estimate of anticipated experience under these programs.

Joan M. Weiss, FSA, EA
Chief Valuation Actuary, PBGC
Member, American Academy of Actuaries

A complete actuarial valuation report, including additional actuarial data tables, is available from PBGC upon request.

Pension Benefit Guaranty Corporation
Office of Inspector General
1200 K Street, N.W., Washington, D.C. 20005-4026

To the Board of Directors
Pension Benefit Guaranty Corporation

We contracted with the independent certified public accounting firm of PricewaterhouseCoopers LLP to audit the financial statements of Single-Employer and Multiemployer Program Funds administered by the Pension Benefit Guaranty Corporation (PBGC) as of the Fiscal Year (FYs) 2003 and 2002. This audit is performed in accordance with auditing standards generally accepted in the United States of America and *Government Auditing Standards* issued by the Comptroller General of the United States and the *GAO/PCIE Financial Audit Manual*.

In its audit of the financial statements of Single-Employer and Multiemployer Program Funds administered by PBGC, PricewaterhouseCoopers found:

- The financial statements were fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles.
- PBGC maintained effective internal control over financial reporting (including safeguarding assets) and compliance with laws and regulations, except for a material weakness related to the methodology used in estimating multiemployer plan liabilities.
- No reportable noncompliance with laws and regulations it tested.

In addition, PricewaterhouseCoopers described significant matters in the following areas where PBGC needs to:

- integrate its financial management systems;
- complete its efforts to fully implement and enforce an effective information security program;
- improve controls related to single-employer premiums;
- continue to improve its controls over the identification and measurement of Single-Employer Program Fund contingent liabilities;
- improve controls over the estimation of reserves for Single-Employer Program Fund losses incurred but not reported or not specifically identified; and
- strengthen controls over the identification and classification of Multiemployer plans probable of receiving financial assistance.

PricewaterhouseCoopers is responsible for the accompanying auditor's report dated December 22, 2003 and the conclusions expressed in the report. We do not express opinions on PBGC's financial statements or internal control or conclusions on compliance with laws and regulations.

A set of PricewaterhouseCoopers' reports (2004-2/23176-2) is available upon request from the PBGC's Office of Inspector General.

Sincerely,

Robert L. Emmons
Inspector General

December 22, 2003

PRICEWATERHOUSECOOPERS

PricewaterhouseCoopers LLP
1301 K Street, N.W. 800W
Washington DC 20005-3333
Telephone (202) 414 1000

Report of Independent Auditors

To the Inspector General
Pension Benefit Guaranty Corporation

We have audited the accompanying statements of financial condition of the Single-Employer and Multiemployer Program Funds administered by the Pension Benefit Guaranty Corporation (PBGC) as of September 30, 2003 and 2002, and the related statements of operations and changes in net position and of cash flows for the years then ended. These financial statements are the responsibility of PBGC's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Single-Employer and Multiemployer Program Funds administered by PBGC at September 30, 2003 and 2002, and the results of their operations and their cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

By law, PBGC's Single-Employer and Multiemployer Program Funds (the Funds) must be self-sustaining, and therefore their premiums must be sufficient to cover both their short and long-term obligations. The Funds have been able to meet their short-term benefit obligations, and PBGC internal analyses project that they will be able to do so for a number of years. However, as discussed in Note 1, management believes that neither program at present has the resources to fully satisfy PBGC's long-term obligations to plan participants. The Funds' statements of financial condition report a net deficit position (liabilities in excess of assets) of the Single-Employer and Multiemployer Program Funds of $11.2 billion and $261 million, respectively, at September 30, 2003. Losses that are "reasonably possible" as a result of unfunded vested benefits are estimated to be $85.5 billion and $63 million for Single-Employer and Multiemployer Program Funds, respectively, at September 30, 2003, as discussed in Note 7. The Funds' net position, and long-term viability, could be further impacted by losses from plans classified as reasonably possible (or from other plans not yet identified as potential losses) as a result of deteriorating economic conditions, the insolvency of a large plan sponsor or other factors.

Management's discussion and analysis, the Actuarial Valuation, and other supplemental information contain a wide range of data, some of which are not directly related to the financial statements. We do not express an opinion on this information. However, we compared this information for consistency with the financial statements and discussed the methods of measurement and presentation with PBGC officials. Based on this limited work, we found no material inconsistencies with the financial statements.

In accordance with *Government Auditing Standards*, we have also issued our reports dated December 22, 2003 on the effectiveness of PBGC's internal control and on our tests of its compliance with certain provisions of laws and regulations. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

PricewaterhouseCoopers LLP

December 22, 2003

2004-1/23176-1

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John W. Snow
Secretary of the Treasury

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Secretary of Commerce

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Hazel Broadnax
Deputy Executive Director and Chief Financial Officer

Joseph Grant
Deputy Executive Director and Chief Operating Officer

John Seal
Deputy Executive Director and Chief Management Officer

Richard W. Hartt
Assistant Executive Director/ Chief Technology Officer

Vincent Snowbarger
Assistant Executive Director for Legislative Affairs

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Communications and Public Affairs Department

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Robert L. Emmons
Inspector General
[reports directly to the Chairman of the Board]

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Kathleen M. Blunt, *Director*
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Theodore J. Winter, Jr., *Director*
Financial Operations Department and *Treasurer*

* *Retired after year-end*

THE PBGC ADVISORY COMMITTEE

Appointed by the President of the United States

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Kraw & Kraw

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Washington, DC
The Segal Company

FINANCIAL SUMMARY

SINGLE-EMPLOYER PROGRAM

(Dollars in millions)	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994
				Fiscal Year Ended September 30,						
Summary of Operations:										
Premium income	**$ 948**	787	821	807	902	966	1,067	1,146	838	955
Other income	**$ 28**	28	23	5	3	10	19	26	18	42
Investment income (loss)	**$ 3,349**	170	(843)	2,392	728	2,118	2,687	915	1,956	(380)
Actuarial charges (credits)	**$ 6,161**	2,802	1,082	453	(602)	815	488	632	1,561	(926)
Losses (credits) from completed and probable terminations	**$ 5,377**	9,313	705	(80)	49	584	489	118	169	(249)
Administrative and investment expenses	**$ 290**	225	184	167	161	158	155	150	138	135
Other expenses	**$ 97**	15	2	(2)	(1)	6	29	3	19	0
Net income (loss)	**$ (7,600)**	(11,370)	(1,972)	2,666	2,026	1,531	2,612	1,184	925	1,657
Summary of Financial Position:										
Cash and investments	**$ 33,215**	24,851	21,010	20,409	17,965	17,345	14,988	11,665	10,026	7,857
Total assets	**$ 34,016**	25,430	21,768	20,830	18,431	17,631	15,314	12,043	10,371	8,281
Present value of future benefits	**$ 44,641**	28,619	13,497	10,631	11,073	12,281	11,497	10,760	10,388	9,215
Net position	**$(11,238)**	(3,638)	7,732	9,704	7,038	5,012	3,481	869	(315)	(1,240)
Insurance Activity:										
Benefits paid	**$ 2,488**	1,537	1,043	902	901	847	823	790	761	719
Participants receiving monthly benefits at end of year	**458,800**	344,310	268,090	226,080	214,160	208,450	204,800	198,600	181,000	172,800
Plans trusteed and pending trusteeship by PBGC	**3,277**	3,122	2,965	2,864	2,775	2,655	2,500	2,338	2,084	1,961

MULTIEMPLOYER PROGRAM

(Dollars in millions)	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994
				Fiscal Year Ended September 30,						
Summary of Operations:										
Premium income	**$ 25**	25	24	24	23	23	23	22	22	23
Other income	**$ 0**	0	0	0	0	0	0	1	0	0
Investment income (loss)	**$ 37**	118	95	70	(56)	133	68	12	83	(46)
Actuarial charges (credits)	**$ 1**	0	1	0	0	0	(1)	1	2	(1)
Losses (gains) from financial assistance	**$ 480**	101	269	26	109	34	(3)	102	108	57
Administrative and investment expenses	**$ 0**	0	0	0	0	0	0	0	0	0
Net income (loss)	**$ (419)**	42	(151)	68	(142)	122	95	(68)	(5)	(79)
Summary of Financial Position:										
Cash and investments	**$ 984**	933	796	682	681	736	585	498	472	374
Total assets	**$ 1,000**	944	807	694	692	745	596	505	477	378
Present value of future benefits	**$ 3**	3	4	4	5	6	7	9	10	10
Nonrecoverable future financial assistance, present value	**$ 1,250**	775	679	414	479	389	361	365	268	164
Net position	**$ (261)**	158	116	267	199	341	219	124	192	197
Insurance Activity:										
Benefits paid	**$ 1**	1	1	1	1	1	1	2	2	2
Participants receiving monthly benefits from PBGC at end of year	**390**	460	510	620	730	850	1,000	1,100	1,300	1,400
Plans receiving financial assistance from PBGC	**24**	23	22	21	21	18	14	12	9	8

ITEM 21—NATIONAL ENDOWMENT FOR THE ARTS

SUMMARY OF ACTIVITIES RELATING TO OLDER AMERICANS 2001–2002

INTRODUCTION

The National Endowment for the Arts is an independent federal agency that exists to foster, preserve, and promote excellence in the arts, to bring art to all Americans, and to provide leadership in arts education. This agency enthusiastically seeks ways to involve older adults in the arts as creators, teachers, students, volunteers, patrons, and as audience members. Through its support, leadership initiatives, and technical assistance, the Arts Endowment assures the continued involvement of older Americans in the full spectrum of America's art.

OFFICE FOR ACCESSABILITY

This Office serves as the advocacy and technical assistance arm of the Arts Endowment for people who are older, disabled, or living in institutions. The Office works in a myriad of ways to assist grantees and applicants in making arts programs available to these important segments of our citizenry. A broad range of cooperative efforts have been developed with Endowment grantees, arts service groups, private groups representing older and disabled populations, and with other Federal agencies to assist in achieving the Endowment's goal of increased access to the arts for all Americans. The focus of these efforts is inclusion—opening up existing programs and outreach to citizens who would not otherwise have opportunities to be involved in excellence in the arts.

DESIGN FOR THE LIFESPAN FORUM

As part of its efforts to educate and assist the practice of universal design, the Endowment convened a forum, "Design for the Lifespan," in partnership with the American Association of Retired Persons (AARP) and the National Association of Home Builders (NAHB) on February 20–21, 2001. Universal design goes beyond minimum access standards and guidelines—to make spaces and programs usable by people from childhood into their oldest years. This meeting was the first time that remodelers, universal design experts, and consumers came together to look at ways to educate remodelers on incorporating universal design standards into the remodeling process of homes. The AARP's research indicates that Americans want to remain in their homes as they age, and the utilization of universal design principals in building and remodeling homes makes this possible. An action plan, developed by the 26

participants, is being implemented by NAHB and AARP. One of the outcomes of this highly successful meeting was the development of an "Aging In Place" training certification program by NAHB's Senior Housing Research Center. More than 200 remodelers have been certified since the program was launched in April 2002.

National Accessibility Leadership Award

The Arts Endowment developed a National Accessibility Leadership Award with the Coco-Cola Foundation and National Assembly of State Arts Agencies (NASAA) to recognize outstanding work of the State arts agencies. The $30,000 award must be used to advance the agency's access efforts. The first award was presented to the Ohio Arts Council on October 19, 2002, at NASAA's conference in Detroit, Michigan—for its exceptional accessibility work to involve older artists and artists with disabilities in its planning process. The Ohio Arts Council is the only State arts agency to date that requires an older adult or a person with a disability serve on all application review panels and sponsors quarterly meetings of artists with disabilities and of all ages.

Careers in the Arts for Citizens of All Ages and People with Disabilities

The Arts Endowment joined with the Social Security Administration (SSA) and VSA arts to support a series of statewide forums on Careers in the Arts to assist artists and arts administrators with disabilities in increasing their arts training and career opportunities. During this reporting period, forums were convened in Minnesota, New Mexico, and Maryland. Representatives from the SSA, arts schools, arts organizations, and hundreds of older adults and people with disabilities participated in the forums. Most important, many follow-up projects have resulted to assist participants in realizing their career goals.

On October 5, 2001, the AccessAbility Office received the "2002 Arts and Culture Award" from the Corporation on Telecommunication and Disability for the "Endowment's Careers in the Arts Leadership initiative and its ongoing work to make the arts fully accessible to people of all ages and abilities."

Gallaudet University's Deaf Way

As part of the second International Deaf Way Cultural Arts Festival, the Arts Endowment supported an Artists' Symposium that took place June 30-July 6, 2002, at Gallaudet University and at venues throughout the District of Columbia including the Kennedy Center, Smithsonian Institution, Clarice Smith Performing Arts Center at the University of Maryland, and at many art galleries. It was a unique opportunity for approximately 400 deaf artists of all ages and disciplines to come together to show and share their art—many for the first time. The artists exhibited and performed their art, and conducted master classes and arts workshops for festival participants. The Symposium served to increase public awareness of the abilities and accomplishments of deaf and hard-of-hear-

ing artists of all ages and to establish lasting collaborations between deaf or hard-of-hearing artists and arts organizations.

CREATIVITY AND AGING STUDY

The Arts Endowment developed a partnership with the American Association of Retired Persons, the Guttman Foundation, and the U.S. Dept. of Health and Human Services (Administration on Aging and National Institutes of Health) to support a three-year study, "The Impact of the Arts on Older Americans," to measure and evaluate the effects that professional arts programs have on the quality of life for older adults. The Endowment hosted an interagency signing ceremony on July 24, 2001, to formally recognize this alliance and the interagency committee that oversees the study.

The purpose of this study is to examine the impact of community-based cultural programs on the physical health, mental health, and social functioning of older persons. The study involves older adults participating in a wide variety of cultural programs conducted by professional artists including visual artists, storytellers, poets, dancers, and theater artists. The research is being conducted in three locations that offer important population diversity and variation in art forms: Elders Share the Arts in Brooklyn, NY; Artworks in San Francisco, CA, and the Levine School of Music in Arlington and Alexandria, VA. Participants represent demographic diversity in terms of race and ethnicity. As needed, test instruments are translated into Spanish and Asian languages, and are administered by trained research assistants who speak that language.

This is the first study of its nature in which an experimental design is employed using a large intervention group of older adults involved in community-based cultural programs conducted by professional artists that is compared to a large control group of older persons not participating in such programs. Although there are no definitive studies to date, experience has shown dramatic improvements in the lives of older adults when they are involved in structured programs conducted by professional artists over a period of time.

Preliminary results of the study were presented to an enthusiastic audience at the April 2002 meeting of the American Society on Aging. Scientific and community service program interest in the study has been high as well. The outcomes anticipated in the study are on the whole expected to reflect changes in the direction of promoting sustained if not enhanced societal functioning and independence. The goal is to significantly increase the involvement of older Americans in high quality cultural programming.

THE ARTS IN HEALTHCARE

The Arts Endowment continues its leadership initiative to infuse professional arts programming into healthcare including programs at hospitals, drug treatment centers, and hospices. During this reporting period, the Endowment supported the Arts in Healthcare Consultants' Program with the Society for the Arts in Healthcare,

a national membership organization that includes medical professionals, arts administrators, artists, and business representatives.

Seventeen arts administrators serve as consultants to advise and assist medical staff in planning, developing, and establishing arts programming in their facilities. Programs include concerts in hospital lobbies; strolling musicians in patients rooms; story tellers for children; drawing and painting instruction; art exhibitions in corridors and waiting rooms; and art carts where patients select framed art for their rooms. In addition, the AccessAbility Office convened workshops for state and regional arts agencies to assist them in expanding the arts into healthcare settings throughout the country.

ARTS ENDOWMENT FUNDING

The National Endowment for the Arts supports arts activities that benefit people of all ages. The projects described below specifically address arts programming for older adults.

Please note that our report describes grants awarded for Fiscal Years 2001 and 2002.

FY 2001 Grants

DANCE

Ririe-Woodbury Dance Foundation in Salt Lake City, Utah, offered a variety of dance workshops to people of all ages residing in Louisiana. Residencies ranged from Afro-Caribbean dance and creative movement workshops held in local schools to ballroom dancing for older adults.

Stuart Pimsler Dance Theater in Minneapolis, Minnesota, collaborated with two healthcare organizations, Pathways and Virginia Piper Cancer Institute's Arts and Humanities program, on a new project, Stories to Die For, involving caregivers and persons with life-threatening illnesses.

DESIGN

American Institute of Graphic Arts in Seattle, Washington, organized an intergenerational book project that brought together inner-city school children, older adults and graphic designers in a ten-week workshop. A set of books created by the participants was published and distributed to the community.

Mississippi State University in Jackson, Mississippi, received funding for a consortium project about the design of affordable, innovative, prototype housing for a cooperative living arrangement. The project, implemented by the Jackson Community Design Center of Mississippi State University and Stewpot Community Services, brings together a living arrangement of low income, single parent families, older adults and individuals with disabilities.

LOCAL ARTS AGENCY

Regional Arts and Culture Council of Portland, Oregon, organized the Arts in Healthcare Consortium that brings multifaceted, professional arts programs into healthcare facilities in the Portland metropolitan region. Media Rights, a radio piece on death and

dying, focused on end-of-life issues. The Artist Repertoire Theater at the Well Arts Institute worked with veterans who told their stories and saw them dramatized in theater, and artists conducted programs at Emmanuel Children's Hospital and targeted children and their families.

MEDIA ARTS

Film Arts Foundation of San Francisco, California, received funding for the production of an experimental documentary film by Ellen Bruno on aging, sickness, and death entitled "Skin and Bones."

Jack Straw Foundation in Seattle, Washington, received support for its Blind Audio Project. The project consists of a series of workshops introducing people who are blind or partially sighted to the creative possibilities and latest techniques of audio production.

L.A. Theatre Works in Venice, California, distributed audio plays to libraries for people who are blind or partially sighted, and provided organizations with promotional materials to enhance the collection.

MULTI DISCIPLINARY

Arizona Theatre Company in Tucson, Arizona, received Endowment support for its consortium project, ARTability: Accessing Arizona's Arts. This statewide community outreach and professional training project expands and promotes accessible programming to individuals with disabilities.

Arts for the Aging, Inc., in Bethesda, Maryland, expanded its Arts Workshop Program with support from the NEA. The project provides monthly instruction by professional artists at senior daycare centers in metropolitan Washington, DC.

Danceworks, Inc., of Milwaukee, Wisconsin, organized its 50-Plus Initiative, a dance and creative arts program for older adults. Workshops, classes, residencies, and performances include older adult with physical and cognitive disabilities.

Elders Share the Arts in Brooklyn, New York, was awarded a grant to support its Center for Creative Aging, a national arts-in-aging training program that links cultures and generations. The project relies on its national networking program to develop model programs such as Generating Community, an intergenerational program that brings together older adults in nursing homes, community centers, and senior centers with pre-school to high-school aged youth. Their Pearls of Wisdom group is composed of elder storytellers who represent New York's older generation and its cultural diversity and performs in schools and senior facilities.

Gallaudet University in Washington, DC, received Endowment support for The Deaf Way II, the University's second weeklong international festival that celebrates the experiences of people who are deaf and focuses on universal issues such as the arts, language, culture, technology, and human rights. The festival was held on July 8–13, 2002, at the Washington Convention Center. In addition, an elaborate arts festival was held at venues around the city, including exhibitions and performances by deaf artists.

Sheboygan Arts Foundation, Inc., in Sheboygan, Wisconsin, received a grant for Connecting Communities, a series of community-based arts residencies that facilitate collaborations between visual and performing artists and older adults, industrial employees, youth at risk, and members of the Hmong and Hispanic communities of Sheboygan County.

Society for the Arts in Healthcare in Washington, DC, was awarded funding for the second phase of the first national technical assistance project, an initiative that trains arts administrators and artists as consultants to healthcare institutions across the country. These consultants assist healthcare groups in establishing comprehensive, professional arts programming within their institutions.

MUSIC

Flint Institute of Music in Flint, Michigan, created music outreach activities for underserved communities. Performances and other activities for children and adults were presented at senior centers, public housing projects, and recreation centers.

Washington Chorus. Inc., in Washington, DC, was awarded a grant for an outreach and education program, including free concerts for older adults, school choir workshops, and distribution of free tickets to underserved groups throughout the Washington, DC, area.

MUSICAL THEATER

American Music Theater Festival, Inc., in Philadelphia, Pennsylvania, brought diverse communities together with Project Open Doors, a multi-faceted project with complementary artistic, educational, and marketing components. Prince Music Theater widened access to musical theater through low or no-cost performances by and for people with disabilities and people with low incomes. They also organized residencies in schools for artists of all ages who composed original work with the children.

OPERA

Lyric Opera of Kansas City, Inc., in Kansas City, Missouri, received a grant to create educational programs for pre-K through 12th grade students, inmates in correctional facilities, and the families of both. In FY 2001–2002, programs included "Lyric Opera Express" and "Opera for Teens." The opera also provided professional development opportunities for educators in Kansas and Missouri.

RESOURCES FOR CHANGE: TECHNOLOGY

Deaf West Theatre Company, Inc., of North Hollywood, California, designed backstage communication systems for technicians who are deaf and hard-of-hearing, installed a computer-operated control board for technical effects, and developed lighting that robotically focuses on signing interpreters or actors with funds from the Endowment. The project trained technicians who are deaf or hard-of-hearing for jobs in the theater and worked to enhance

the theater experience for audiences who are deaf and hard-of-hearing.

Music and Arts Center for Humanity of Bridgeport, Connecticut, received a grant to develop online services for the National Resource Center for Blind Musicians. Using new Cake Talk software as a base, the center implemented a distance-learning course on the Web for students and teachers to interchange Braille music notation and scoring suited only for sighted individuals.

THEATER

Center Stage Associates, Inc., in Baltimore, Maryland, was awarded funding to support the adaptation and presentation of J.M. Barrie's Peter Pan. The production included actors and musicians of all ages who are both deaf and hearing.

Contemporary American Theater Festival of Shepherdstown, West Virginia, purchased and installed infrared assistive listening systems. Systems were installed in two theaters and increased the participation and comfort of audience members who are hard-of-hearing.

Deaf West Theatre Company, Inc., in North Hollywood, California, created a new theater piece and video. Mark Medoff, author of Children of a Lesser God, was commissioned to write the new theater piece that is accessible to audiences who are both deaf and hearing.

Non-Traditional Casting Project, Inc., of New York, New York, received Endowment support for its Artist Files/Online and the National Forum on Diversity:The American Scene. These initiatives link theater producers with artists of color, older artists, and artists with disabilities to promote a national dialogue concerning diversity and inclusion.

Seven Stages, Inc., in Atlanta, Georgia, received funding for the production and tour of Hush, the story of Blind Tom Wiggins. This world premiere, written by African-American playwright Robert Earl Price, was performed at Seven Stages in Atlanta and toured to select communities throughout the Southeast.

Theater By the Blind Corporation in New York, New York, was awarded a grant to expand training and professional development for theater artists who are blind or partially sighted. Theater By the Blind increases access to play scripts and theater texts for people who are blind or partially sighted through its reading service and staged reading performance opportunities.

Theater Development Fund, Inc., of New York, New York, organized Interpreting for the Theater, an intensive one-week course on theater sign-language interpretation. The Fund convened an advanced training program for certified interpreters nationwide to hone their skills as theater sign interpreters and to explore techniques for signing plays and musicals.

VISUAL ARTS

Richmond Art Center of Richmond, California, was awarded a grant to support the Quilt of Many Colors Project, a series of four curated exhibitions installed in the lobbies of Richmond's main public health facility. The project promotes the value of the arts in

the healing process and provides access to the arts for approximately 30,000 people who enter the facility each year.

FY 2002 Grants

DANCE

Caribbean Dance Company of the Virgin Islands, Inc., in St. Croix, Virgin Islands, received support for its 2002 Caribbean Dance Axis. The project provides performances at senior centers, universities, elementary schools, and public daycare centers.

Dance Alive!, Inc., in Gainesville, Florida, received a grant to expand its touring into rural and underserved areas of Florida, Georgia, Alabama, and Louisiana. The dance programs include work by resident choreographers, George Balanchine, and commissioned work by contemporary choreographers.

San Diego Dance Theater in San Diego, California, was awarded funding for the Dance Ability Project. This project partners dancers and choreographers of all ages with physical education teachers to create dances that generate performance opportunities for students with disabilities of the Oceanside School District.

Tigertail Productions, Inc., in Miami, Florida, and Florida Dance Association presented danceAble III, a five-day series of performances, workshops, panels and symposia dedicated to exploring and promoting dance for people of all ages with disabilities, during the Florida Dance Festival in Miami on June 24–29, 2002. The danceAble strives to broaden the definition of dance and to expand the understanding of who has access to dance. It recognizes the many health and creative benefits of dance and is targeted to a general dance audience, attendees of the Florida Dance Festival, health professionals, artists and individuals of all ages from the community.

DESIGN

Archeworks in Chicago, Illinois, was awarded a grant for the design and production of a prototype kitchen that is usable by everyone including individuals with physical disabilities. Archeworks is an alternative design school founded to initiate design solutions for intergenerational and underserved communities.

Architects/Designers/Planners for Social Responsibility in Berkeley, California, was awarded funds to support New Village Journal, a publication that presents case studies of grassroots projects concerned with cultural heritage and neighborhood spirit. These projects serve older adults, immigrant communities, children and youth, and will feature examples of cultural and physical renewal in some of the most challenged urban neighborhoods in America.

Mercy Housing in Flagstaff, Arizona, received funds on behalf of Indigenous Community Enterprises for a housing project designed for older Navajos that incorporates traditional Navajo dwelling designs with contemporary housing design features. Design workshops that include a variety of ages and cultural perspectives were conducted with older Navajos, tribal officials, community leaders, social service providers, facility managers, and family members.

Rhode Island School of Design in Providence, Rhode Island, is developing a project, The Knowing Eye, which includes interactive learning spaces throughout the permanent collection of the RISD Museum. Its purpose is to encourage the active engagement of visitors of all ages with the exhibits.

VSA arts of Massachusetts in Boston, Massachusetts, received funding for expansion of its National Cultural Access Initiative. This initiative demonstrates the principles of universal design and creates opportunities for broad participation in the arts through a national tour of JazzArtSigns, a group that includes musicians, an improvisational painter, American Sign Language (ASL) interpreters, live audio description and text captioning, and program information in Braille and large print. It also provides a training videotape that is open-captioned and audio-described to introduce the concept of universal design to program presenters through affiliates in 28 states.

FOLK AND TRADITIONAL ARTS

Los Reyes de Albuquerque Foundation in Albuquerque, New Mexico, received support to maintain nuevomexicano folk traditions and to present specially arranged performances of the Fiesta de los Novios at urban, rural, and Pueblo senior centers and child daycare centers.

Maine Indian Basketmakers Alliance in Old Town, Maine, was awarded funds for the Next Generation Project, an intertribal/intergenerational initiative that engages tribal members between the ages of 13–30 in one-on-one apprenticeships with master weavers.

Richmond Art Center in Richmond, California, received a grant for its Quilt of Many Colors Project, a series of four curated exhibitions installed in the waiting room of Richmond's main public health facility. The project promotes the value of the arts in the healing process.

LEADERSHIP INITIATIVES

ARTREACH, Inc., in Philadelphia, Pennsylvania, was awarded a grant for its Outreach Project, an expansion of ARTREACH's ticketing program. ARTREACH, Inc., coordinates, distributes, and donates tickets at significantly discounted prices for music, dance, and theater performances. The agency increases outreach to agencies that serve older adults, people with disabilities, and individuals with low incomes.

Asian Arts Initiative in Philadelphia, Pennsylvania, acting as the lead organization in consortium with other groups, received funds for the Artists in Communities Training Program. Two 50-hour training sessions are offered to artists for training in arts education to serve residencies in multigenerational community settings across Philadelphia.

Class Acts Arts, Inc., in Silver Spring, Maryland, received a grant to expand outreach programs to underserved populations and develop access programs for people who are deaf or hard-of-hearing. The project focuses on accessibility needs and includes work-

shops with master artists, new learning guides, and other support material for teachers.

Elders Share the Arts in Brooklyn, New York, completed Level 2 of its consortium project at the National Center for Creative Aging, an arts-in-aging training program. Project activities include the maintenance of current arts-in-training programs in five regions of the country, expanded training to additional cities, creation of a network newsletter, and the development of an online component that highlights model arts programs involving older adults.

LITERATURE

National Book Foundation, Inc., in New York, New York, was awarded funding for its literary outreach programs that link National Book Award authors with underserved, intergenerational communities throughout the country. Programs include American Voices, which brings writers to Native American reservations nationwide, and a Summer Writing Camp for inner-city residents, whose ages range from 14 to 70.

MEDIA ARTS

Detroit Educational Television Foundation in Detroit, Michigan, received support to develop a documentary on Vietnam War veterans as artists. Through the Green Door includes material from the National Vietnam Veterans' Art Museum in Chicago where more than 140 artists' works are exhibited.

Jack Straw Memorial Foundation in Seattle, Washington, acting as the lead organization in a consortium with other groups, received funds to further its Blind Youth and Adult Audio Project. Arts and Visually Impaired Audiences presents a series of workshops that introduce people who are blind or partially sighted to the creative possibilities and latest techniques of audio production.

MULTIDISCIPLINARY

Community School of the Arts in Charlotte, North Carolina, created after-school and intergenerational arts programming with support from the Endowment. Children and adults from the Southside Homes public housing community participated in on-site workshops and classes in visual art, drama, and music.

Great Leap, Inc., in Los Angeles, California, received support for its multi-year project To All Relations: Re-spiriting Detroit. This intergenerational project focuses on community efforts to rebuild, re-spirit, and redefine Detroit utilizing dance, music, and storytelling to create a work entitled, "I Dream a Garden," a song written and performed as a community circle dance. Involving community groups, the Boggs Center, Detroit Summer, and the Matrix Theatre Company, the project engages older Americans as well as children and teens from the Asian American, African American, White, Latino, and Native American communities. Older adults are involved in the project's conception and implementation, serving as storytellers and dancers.

Little City Foundation in Palatine, Illinois, organized Have Art, Will Travel, a series of mobile arts classes that provide children

and adults with developmental disabilities with instruction in the visual, performing and media arts.

Office of Human Concern, Inc., in Rogers, Arkansas, was awarded a grant on behalf of The Multicultural Center of Northwest Arkansas to support the Marshallese Traditional Arts Summer Program where older adults pass on dance, music, and handicraft traditions to their youth.

Senior Arts Project in Albuquerque, New Mexico, was awarded a grant for its Senior Arts Festival International. The project features a day-long, inter-generational celebration for the 350-member multigenerational audience, 95 percent of whom are older adults. Performances by six multi-ethnic performing groups, a series of workshops, and a social dance encourages broad audience participation.

Sheboygan Arts Foundation, Inc., in Sheboygan, Wisconsin, received funding on behalf of the John Michael Kohler Arts Center to support Connecting Communities, a series of five community-based residencies that facilitate collaborations between visual and performing artists and older audiences from Sheboygan County, the Hmong and Hispanic communities, industrial employees, and youth at-risk.

VSA arts of Washington in Seattle, Washington, received support for its Cultural Access Project of Washington State. The project increases access to arts organizations for older individuals and people with disabilities by assisting in the evaluation and education of organizations concerning access to all facets of their facilities and programs.

Walt Whitman Cultural Arts Center, Inc., in Camden, New Jersey, received a grant to expand its artist residency and workshop program. Ten local and community teaching artists will work with underserved city residents including older adults.

Washington Chorus, Inc., in Washington, DC, received a grant to support its outreach and education program. Activities include free concerts for older adults and school choir workshops.

Young Audiences Inc., in New York, New York, was awarded funding for Family Link, a program providing underserved public school students and families with intergenerational arts education programming as well as access to New York City's cultural resources. The initiative provides public school students, teachers, and families with multicultural learning opportunities through in-school residencies, family workshops, and artist visits to performances.

MUSEUMS

Museum of Photographic Arts in San Diego, California, organized the Regeneration Project, a 16-week collaborative creative process involving older adults and local artists. Working with professional photographers, actors, composers, designers and arts educators, older adults write, direct, and present a multimedia performance piece.

Texas Fine Arts Association in Austin, Texas, was awarded funding to support "Art on Tour," a statewide traveling exhibition program with accompanying catalogues and lectures. The program circulates exhibitions of contemporary art by emerging and mid-career

American artists to small museums and university and community galleries throughout Texas, many in rural, culturally underserved communities.

MUSIC

Billings Symphony Society in Billings, Montana, received a grant for its Yellowstone Music Project that includes the Senior Series, a program that takes small ensembles and soloists into lunch centers and transitional care facilities, a free Youth Concert that is accessible to everyone, and a free symphony in the park that reaches 10,000 people.

Flint Institute of Music in Flint, Michigan, was awarded funding to support music outreach activities for local, underserved communities. Performances and other activities are presented at senior centers, recreation centers, and public housing projects.

Grand Performances in Los Angeles, California, received a grant for its multidisciplinary series of hip-hop presentations including intergenerational hip hop poetry classes conducted by Watts Prophets, and a performance by Watts Prophets entitled "MMM: Music, and Movement and Meaning" with post-performance facilitated discussions. Performances are advertised in the downtown senior centers, and open rehearsals for the orchestra are held in an outdoor facility. Focused on local roots, this free series broadens the involvement of young audiences in the arts and introduces intergenerational audiences to the artistry of hip-hop.

Houston Grand Opera Association, Inc., in Houston, Texas, completed the seventh season of its Community Connections Initiative that demonstrates unique methods for developing new audiences for opera. The program offers free performances of three operas each year to schools and community centers, audiences at the Heinen and Miller Outdoor theaters, and in several branches of the Library. In addition, a special "Plazacast" of a popular production is provided annually projecting a live performance onto a giant outdoor screen making it available to audiences of all ages.

Houston Symphony Society in Houston, Texas, received support to further Community Connections, an outreach project for underserved communities. During 2002, the Houston Symphony's musicians performed at long-term care facilities, community centers, hospitals, and schools.

Nashville Symphony Association in Nashville, Tennessee, received funding for its concerts in rural areas of middle Tennessee and southern Kentucky. The Nashville Symphony, in partnership with local community organizations, will tour to diverse and underserved communities.

New Cleveland Opera Company in Cleveland, Ohio, sponsors an inter-generational initiative that encourages the inclusion of parents, extended families, and residents of local senior centers in programs with students. Using the company's core K–12 programs as a model, the initiative reached an estimated 21,000 underserved persons through programs in 26 schools in 2002. The company estimates that 20 percent of the schools participating in its programs now regularly include activities with parents, grandparents, and friends.

THEATER

Capital Repertory Company in Albany, New York, expanded its efforts to provide accommodations for hard-of-hearing and deaf audience members. Plans include the installation of an infrared assisted listening system and professional sign language interpreters for designated performances.

City Theatre Company, Inc., in Pittsburgh, Pennsylvania, was awarded funding for a community outreach initiative. Spearheaded by the Community Relations Department of City Theatre, the project was created to increase access to programming, events, and activities for underserved populations including communities with low household incomes, older adults, and people with disabilities.

Creative Access in Philadelphia, Pennsylvania, received a grant to provide accessible programming at museums and venues featuring local and regional theater for people who are deaf and hard-of-hearing.

Dallas Theater Center in Dallas, Texas, received a grant for a theater touring program that is accessible to all audiences. Dallas Theater Center will tour an adaptation of Sophocles' tragedy Antigone to regional schools with underserved populations, juvenile detention centers, senior centers, and other community organizations.

Deaf West Theatre Company, Inc., in North Hollywood, California, organized the tour and production of professional deaf theater for new and diverse audiences in New York City with funding from the Endowment. Deaf West Theatre Company identified and secured a venue in New York to co-produce the musical production of Oliver! in American Sign Language.

Dixon Place Theatre in New York, New York, received a grant for its Intergenerational Performance Workshops, a program that provided drama courses to underserved older adults, youth, and people residing at public housing facilities in the Rosehill section of Manhattan. Artists convene weekly workshops and instruct older adults in performing group scenes, monologues, and in writing their own solo pieces. Adults and youth perform the pieces at a three-day festival in October.

El Teatro de la Esperanza in San Francisco, California, received a grant for a modern secular adaptation of Las Posadas Mojadas, a seasonal pageant and play about immigrants seeking refuge. The adaptation is designed as a touring production that brings theater to underserved audiences in San Francisco and nationwide.

L.A. Theatre Works in Venice, California, received a grant to distribute two audio plays made for radio that are accessible to all audiences. The plays reached 2,500 underserved public secondary schools and 700 public libraries, including many specifically designed for those who are blind or partially sighted.

Non-Traditional Casting Project, Inc., in New York, New York, continues to present two accessibility initiatives, the National Diversity Forum and Artist Files/Online, with Endowment support. These initiatives link theater producers with artists of color, older artists, and artists with disabilities to promote a national dialogue concerning diversity and inclusion.

Paper Mill Playhouse in Millburn, New Jersey, created an Access Program for this historic playhouse that includes services for peo-

ple who are deaf or hard-of-hearing and barrier-free access for people with physical disabilities.

Pasadena Playhouse State Theater of California, Inc., in Pasadena, California, organized an audience development initiative that provides increased arts access opportunities for people who are deaf or hard-of-hearing and for individuals with low incomes. The program includes signed performances, audio-described performances for people who are blind or visually impaired, and pay-what-you-can opportunities for individuals with limited financial resources.

Penobscot Theatre Company in Bangor, Maine, received funding for a production of The Diary of Anne Frank and an accompanying outreach project. A series of multicultural and intergenerational initiatives for schools, libraries and centers for older adults will engage the theater's community in an examination of bigotry in the contexts of religion, ethnicity, and sexual orientation.

Seattle Shakespeare Festival in Seattle, Washington, was awarded a grant for a Shakespeare festival involving all Seattle School District middle schools and older adults. Participants work with professional actors and production managers from Seattle Shakespeare Festival on rehearsing and performing 90-minute Shakespeare adaptations in a festival format.

Shakespeare Project, Inc., in New York, New York, received a grant to support free outdoor performances of Shakespeare's Othello in parks and public spaces throughout New York City. The production will be targeted at non-traditional audiences and at the communities surrounding the park venues.

Spanish Theatre Repertory Co., in New York, New York, was granted funds to support Teatro Acceso, a tour of theater works performed for multigenerational, underserved communities throughout the New York metropolitan, tri-state area, and the northeastern United States. The Company used grassroots promotional efforts to reach communities of older adults with limited access to the arts and students from underserved schools and Latino communities.

Ten Thousand Things in Minneapolis, Minnesota, was awarded a grant for the presentation and tour of a production of Shakespeare's King Lear. The company toured 16 performances of a highly physical production of King Lear to audiences in correctional institutions, homeless shelters and adult education centers serving low-income people in Minneapolis and St. Paul.

Theatre Development Fund, Inc., in New York, New York, organized Interpreting for the Theatre, an intensive one-week institute for proficient sign language interpreters. The program is designed to improve the skills of certified interpreters who have experience in signing plays and musicals and to maintain national standards of excellence in the field.

Viet Olympiad in Garden Grove, California, staged performances of Cai Luong classical Vietnamese musical theater. Cai Luong expresses the deepest feelings of both old and young in the Vietnamese community, creating intergenerational connections with shared emotions of anger, pain, love, laughter, and sadness.

VSA arts of Georgia, Inc. in Atlanta, Georgia, expanded its theatrical sign language interpreting program. The program offers discounted services to small and mid-sized theater companies in Geor-

gia and professional development opportunities for current and new theatrical interpreters.

Washington Theatre Awards Society in Washington, DC, received a grant to support the Washington Audience Development Initiative, a multimedia promotional campaign to identify and develop new audiences for all Washington theaters. The initiative will work toward developing theater audiences in metropolitan Washington that are representative of area demographics.

Weston Playhouse Theatre in Weston, Vermont, received funding to expand the theater's education and outreach programs for intergenerational, rural, underserved audiences. An audio-described production of Chicago was staged with a pre-show tactile exhibit for all audiences, including individuals who are blind or partially sighted.

Young at Heart Chorus, Inc. in Northampton, Massachusetts, was awarded funding for the revival of an original musical about the French revolution, Louis Lou. The Young At Heart Chorus, an ensemble comprised of older performers, will revive the musical from its repertory.

VISUAL ARTS

Art Resources Transfer, Inc. in New York, New York, received funding for its audience development program that offers free books, museum catalogues, videos and other material about contemporary art to libraries across the nation with a special emphasis on rural and inner-city libraries.

Asian American Arts Centre, Inc., in New York, New York, received a grant to support an intergenerational public art project, Stories of Chinatown, in an underserved community. Organized in collaboration with Elders Share the Arts, the program will bring Chinatown's older adults together with high school youth to create artwork that will present the untold stories of this aging immigrant population in a permanent ceramic tile installation.

COSACOSA art at large, Inc., in Philadelphia, Pennsylvania, was awarded funding for its Healing Art Project, a project that brings individuals in pediatric and adult hospitals, continuing care facilities, local community clinics and social service agencies together with Philadelphia community members to create collaborative public art. Over 600 intergenerational project participants receive instruction each year in workshops with professional artists. Each workshop series identifies a community theme to explore through one of many possible artistic disciplines, including painting, theater, quilt-making and ceramics. Pieces resulting from the Healing Art Project are on display in libraries, schools, and other public places throughout Philadelphia, as well as the Philadelphia International Airport.

Creative Growth, Inc., in Oakland, California, organized a yearlong series of professional studio arts instruction for adults with disabilities, created gallery exhibitions and supported extensive outreach activities with a grant from the Endowment. Professional artists with experience working with people with disabilities taught classes in printmaking, drawing, painting and wood and clay sculpture.

Pyramid Atlantic, Inc., in Riverdale, Maryland, received funding to support a residency program, educational outreach, teacher training and mentorships. The program, designed to explore various media, imagery and the notions of community, will be intergenerational and bilingual, uniting artists, scholars, teachers and youth.

Watershed Center for the Ceramic Arts in Newcastle, Maine, expanded the services of MudMobile, a statewide traveling ceramics program in a van. The MudMobile serves older adults as well as children and people with cognitive and developmental disabilities throughout the state of Maine. Mudmobile takes clay art activities to nursing homes, assisted living sites, and community organizations that serve older Americans. This unique program helps over 300 seniors each year to improve flexibility and coordination, provides a new medium to tell their stories, and allows them to create artistic products that they could share with friends and family.

ITEM 22—POSTAL SERVICE

PROGRAMS AFFECTING OLDER AMERICANS

CARRIER ALERT PROGRAM

Carrier Alert is a voluntary community service provided by city and rural delivery letter carriers who watch participant's mailboxes for mail accumulation which might signal illness or injury. Letter carriers report mail accumulations to their supervisors, who then notify a sponsoring agency, through locally developed procedures, for follow-up action. The program completed its 20th year of operation in 2002 and continues to provide a lifeline to thousands of elderly citizens who live alone.

DELIVERY SERVICE POLICY

The Postal Service has a long-standing policy of granting case-by-case exceptions to delivery regulations based upon hardship or special needs. This policy accommodates the special needs of elderly, handicapped, or infirm customers who are unable to obtain mail from a receptacle located some distance from their home. Information on hardship exceptions to delivery receptacles can be obtained from local postmasters.

SERVICES AVAILABLE FROM YOUR RURAL CARRIER

Rural carriers continue to provide their customers with retail services they have come to expect from the rural "Post Office on wheels." Retail services provided included registered and certified mail, accepting parcels for mailing, and taking applications for money orders. Rural carriers also provide customers with receipts for such services.

Retail services are available to all customers served by rural carriers but are most beneficial to those individuals who are elderly or have physical limitations that adversely impact their ability to go to the Post Office for these important services. Rural carriers provide their customers with almost all retail services available from the Post Office.

PARCEL DELIVERY POLICIES

For postal customers who are unavailable to receive parcels, but who normally are at home, our letter carriers will automatically redeliver the article the following day. In addition, if the mailer requests, uninsured parcels are left at customers' homes or businesses provided there is reasonable protection from weather and theft. Both of these policies make it easier for customers, particu-

larly the elderly, to receive mail and minimize the need for trips to the Post Office.

ACCESSIBILITY

The Postal Service is subject to the Architectural Barriers Act of 1968. The resulting standards for the design, construction, and alteration of leased and owned facilities, are published in Postal Service Handbook RE–4, Standards for Facility Accessibility by the Physically Handicapped.

Significant progress continues to be made to increase the accessibility of 36,000 Postal Service facilities. Our commitment to barrier-free facilities is apparent through the enhanced facility features (such as automatic doors and van-accessible parking) that are part of our national building design standards and are over and above the RE–4 requirements. These benefit physically challenged and elderly customers.

The Postal Service values its elderly customers and believes they will benefit from our efforts to make facilities more accessible.

CONSUMER EDUCATION AND FRAUD PREVENTION INITIATIVES

The Mail Fraud Statute is the oldest and most effective of the consumer protection laws, and the U.S. Postal Inspection Service if the federal law enforcement agency mandated by Congress to enforce it. Educating the public on fraud schemes that involve the mail is an essential component to fulfilling this responsibility.

Mail fraud investigations focus on a variety of schemes conducted through the mail in an effort to ensure the integrity of the mail and to ensure the confidence of government agencies, businesses, and U.S. Postal Service customers. The U.S. Postal Inspection Service works to protect the American public from such schemes, in part by educating people about fraud trends that target various groups, including some of the most vulnerable citizens, the nation's elderly.

Inspectors have initiated a number of fraud prevention projects and participated with consumer protection agencies and other groups to help citizens protect themselves before they become victims of fraud.

NATIONAL FRAUD AGAINST SENIOR CITIZENS AWARENESS WEEK

In 2002, the U.S. Senate passed a resolution designating the week of August 25, 2002, as "National Fraud Against Senior Citizens Awareness Week." On August 26, 2002, the Chief Postal Inspector joined forces with Postmaster General John E. Potter, Federal Trade Commission Chairman Timothy Muris, Department of Justice Assistant Attorney General Michael Chertoff, and representatives of the Royal Canadian Mounted Police to announce the campaign kick off. Betty White, a well-know actress who fits the age range of the targeted group, signed on as spokesperson for the campaign and was featured with the Chief Postal Inspector on CBS's Early Show. A total of 51 press events were held in cities nationwide. Public Service Announcements featuring Betty White were broadcast on television and radio stations; and fraud aware-

ness flyers were mailed to roughly 3 million households of seniors and their families.

OPERATION IDENTITY CRISIS

The U.S. Postal Inspection Service, in conjunction with the U.S. Postal Service, the Federal Trade Commission, the U.S. Secret Service, and various other government agencies and private companies sponsored a national consumer awareness campaign in the month of September 2003: "Operation: Identity Crisis." The campaign focused on identity theft.

The campaign is intended to educate consumers on identity theft schemes and ways to protect themselves and provide prevention tips to businesses to help protect consumer data and ensure privacy. This crime affects all age groups, including older Americans.

The national campaign included the following:

- Posters in Post Office lobbies across the country.
- A national press conference in New York to kick-off the initiative on September 16, 2003.
- Newspaper ads appearing in Sunday editions on September 14 and daily papers on September 16 in markets with the highest number of identity theft complaints (AR, CA, FL, GA, IL, MI, NJ, NY, PA, and TX).
- A three million-piece mailing to residents in the above-listed states.
- The use of Jerry Orbach of television's *Law and Order* as the national spokesman in public service announcements, video messages, and a satellite media tour.
- Internal and external messaging via several Postal Service vehicles, such as Web sites, USPS–TV, and Postal Link.
- The use of inserts in selected mailings.
- A new Inspection Service consumer video on Identity Theft entitled "Identity Crisis."
- A revised U.S. Postal Inspection Service Publication 280 on Identity Theft.

CONSUMER FRAUD

We recognize that fraud is one crime that must rely upon the victim to participate, therefore it is one crime that can be reduced or prevented with education. Accordingly, the U.S. Inspection Service established an unprecedented *Consumer Fraud Fund* to augment its already ambitious fraud prevention programs. The fund was created with monies received from criminal fines and forfeitures where victims could not be identified. The fund was initiated with the sanction of the court and the United States Attorney's offices in two districts in Nebraska and Southern Illinois. Last year marked the first year for the deployment of a $15 million fund that over 3 years will support fraud investigations and projects.

CONSUMER EDUCATION FILMS

The U.S. Postal Inspection Service plans to focus its consumer protection program over the next three years on developing a fraud prevention series of programs to educate the American public and to create consumer awareness on the various fraud schemes being

perpetrated against the public, including many schemes aimed at the elderly population. Working with a production company, the Inspection Service will produce three one hour television programs and nine short training videos for use by the Inspection Service and other agencies for education and prevention. The first in the series of short training videos is now finished and is titled "Identity Crisis".

NATIONAL CONSUMER PROTECTION WEEK

In 1999 and 2000, the U.S. Postal Inspection Service and the Postal Service Consumer Advocate's Office joined the AARP, Consumer Federation of America, Department of Justice, Federal Trade Commission, National Association of Consumer Agency Administrators and National Association of Attorneys General to launch National Consumer Protection Week (NCPW).

From 2001 through 2003, the U.S. Postal Inspection Service partnered with the U.S. Postal Service's Consumer Advocate's office to sponsor seminars and publicity campaigns during National Consumer Protection Week (NCPW). Educating consumers about various types of mail fraud, including identity theft, was the focus of these events.

In 2001, the NCPW theme was "If it's too good to be true, it probably is." Approximately 66,000 mail fraud complaints were received by the U.S. Postal Inspection Service during fiscal year 2001. An educational video news release was produced about in Internet scam that victimized an Ohio teenager when he failed to perceive an item he had ordered on-line and paid for through the mail. Technological advances have provided new avenues for scams that were once perpetuated solely through the use of the U.S. mail.

The NCPW theme for 2002 was "Deceptive Mailings—Don't Be Duped." Over 84,000 mail fraud complaints were received by the U.S. Postal Inspection Service in fiscal year 2002. An education video news release was issued featuring Senators Susan Collins (R–ME) and Carl Levin (D–MI) speaking on the Deceptive Mail Prevention and Enforcement Act. The Act imposed various requirements on sweepstakes mailings, skill contests, facsimile checks, and mailings made to look like government documents; including requiring more clear and conspicuous disclosures displayed in a manner that is readily noticeable, readable, and understandable.

In February 2003, NCPW focused on Identity Theft. Identity theft is currently the fastest growing crime. Government sources and privacy advocates estimate there will be over 1 million victims of identity theft this year. Many victims don't realize their identity has been stolen until an average of 18 months has passed. Also, jurisdictional issues often become a hindrance to the reporting of identity theft. Press events included providing prevention tips to postal customers on various steps they can take to help protect themselves from becoming a victim, and how to report identity theft.

DECEPTIVE MAILINGS

Postal Inspectors worked closely with the Senate Permanent Subcommittee on Investigations regarding sweepstakes and deceptive mailings legislation. As a result, the Deceptive Mail Prevention

and Enforcement Act was passed and signed into law on December 12, 1999. The new law protects consumers, especially seniors, against deceptive mailings and sweepstakes practices by:

- establishing standards for sweepstakes mailings, skill contests and facsimile checks,
- restricting government look-alike documents, and
- creating a uniform notification system allowing individuals to remove their names and addresses from all major sweepstakes mailing list at one time.

Additionally, disclosures will make sure that no purchase is necessary to enter a sweepstakes and that a purchase will not improve consumers' chances of winning a prize. The law also creates strong financial penalties for companies that do not disclose all terms and conditions of a contest.

To make the most effective use of the new statute and protect consumers, the Inspection Service established a Deceptive Mail Enforcement Team, composed of Postal Inspectors, Inspector Attorneys and Inspection Service fraud analysts. The team reviews complaints related to promotional mailings to assess their compliance with the Act.

Postal Inspectors have been encouraged by the finding that many promoters have modified their practices to comply with the law by providing notifications and clearer explanations for customers. Further, the U.S. Postal Service has noted a sharp decline in the number of sweepstakes mailings, as companies adopt new marketing strategies in response to the law. The following is an example of an action taken against a promoter of deceptive mailings this year.

Boston Division Postal Inspectors filed a Consent Decree in New York to prohibit a businessman from making false or misleading representations in his mail order business. The man solicited consumers considered poor credit risks, offering an unsecured credit card with a $4,000 to $7,500 credit limit. Consumers believed they were calling a location in the United States, but Postal Inspectors determined the operation was actually in Quebec, Canada. Inspectors filed a Temporary Restraining Order (TRO) in October 2002, preventing the man from doing further business and freezing the company's assets. He was further restrained from selling or transferring any lists of consumers who had responded to his offer and from using any medium to solicit for credit cards. Approximately $500,000 was frozen by the court via the TRO and will be used to issue refunds to victims.

ADMINISTRATIVE ACTIONS RELATED TO MAIL FRAUD SWEEPSTAKES

In addition to criminal prosecution, Postal Inspectors frequently rely on civil or administrative actions to deter mail fraud. Below is a list of actions taken this year to help stem losses from various fraud schemes.

A Withholding Mail Order (Title 39, USC 3003) enables the U.S. Postal Service to withhold an addresses' mail if they are using a false or assumed name, title or address to conduct or assist with activity that violates 18 USC 1302 (lottery), 1341 (mail fraud) or 1342 (use of a fictitious name or address), until proper identification is provided and the person's right to receive the mail is established. Under 39 USC 3004, the Postal Service may withhold mail

if the address is not a person's residence or business address, allowing them to remain anonymous. An example of a U.S. Postal Inspection Service Withholding Mail Order related to a 2003 administrative action follows:

A Cease and Desist Order was issued on January 6 halting a scheme in which postal customers nationwide were solicited and offered a report advising of entry procedures for sweepstakes offering millions of dollars in possible winnings. The solicitation led customers to believe they were participating in a contest rather than purchasing a report about contests. The requested fee of $39.95 was to be mailed to an address in St. Louis, Missouri, which was actually a United Parcel Service store that forwarded the mail to Vancouver, Canada. The investigation revealed that, between March 2001 and February 2002, approximately 58,000 mail pieces were forwarded to Canada. No contest reports were supplied to fee-paying customers.

FRAUDULENT FOREIGN LOTTERY MAIL

False Representation Orders (FROs) enable Postal Inspectors to stop mailed-in responses to schemes (most of which contain checks) from leaving the United States and return mail to the senders, thereby preventing victim losses.

To further combat illegal foreign lotteries, Postal Inspectors work with U.S. Customs Service officials to stop such offerings from entering the U.S. mail stream, and Customs agents contact Inspectors when they find such mail during border searches. Inspectors detain the mail and provide samples to the Postal Service's Law Department to determine if they meet mailing standards. If the pieces are considered nonmailable, the mailer is notified that the material is subject to destruction and may appeal the notice. If the mailer fails to appeal or loses the appeal, the detained mail is destroyed upon the issuance of a Destruction Order.

Lottery promotions that promise large winnings for little effort target consumers and are often aimed at senior citizens who are most vulnerable to such scams. In one case, a major international lottery promoter was sentenced in Seattle to six months in prison, three years' probation and ordered to forfeit $12 million. Inspectors seized his assets for restitution to the victims and in partial satisfaction of a prior consent agreement.

TELEMARKETING FRAUD

Americans receive thousands of unsolicited phone calls from telemarketers each year trying to sell a variety of products, with older citizens often the target. Many offers are legitimate, but unscrupulous telemarketers can be the smoothest of operators, successfully swindling people out of millions of dollars. Indeed, those on fixed incomes who fall prey to these schemes can lose their entire life savings. Telemarketing fraud robs Americans of billions of dollars annually.

As a result of a multi-agency task force "Project Colt," a United States and Canadian joint law enforcement effort to curb cross-border telemarketing fraud, on March 26, in the District of Massachusetts, a Quebec citizen was sentenced to 10 years' imprisonment, three years' probation and ordered to pay over $1.2 million in res-

titution. The man was charged with directing the operation of a fraudulent telemarketing scheme in Montreal that victimized American citizens; largely elderly. The scheme involved telemarketers posing as attorneys or government officials claiming to have recovered money for persons victimized by previous lottery prize schemes. Victims were required to mail purported taxes and/or fees in advance to have the money released, which they never received. The defendant was also sentenced to two years and three months in prison in Florida for using his scheme to victimize a Florida resident.

STAMPS BY AUTOMATED TELLER MACHINE (ATM)

Stamps by ATM is a convenient way to purchase stamps at a bank's automated teller machine. There are currently over 18,000 ATMs nationwide that dispense stamps. Because many ATMs are accessible 24 hours a day, our customers are able to do banking and buy postage stamps at their convenience. A specially designed sheetlet of 18 First-Class stamps is dispensed at the touch of a button. Financial institutions may add a surcharge to the face value of the stamps to cover their processing costs. The cost is debited from the customer's checking or savings account and treated like a cash withdrawal.

STAMPS BY MAIL

Stamps by Mail is a service that allows customers to purchase stamps in booklets, sheets and coils along with other products such as post cards and stamped envelopes, by ordering through the mail.

The Stamps by Mail program benefits a wide variety of people and is particularly beneficial to elderly or shut-in customers who cannot travel to the Post Office. Stamps by Mail provides order forms incorporated in self-addressed postage-paid envelopes to customers for their convenience in obtaining products and services without having to visit a Postal Service retail unit. The form is available in lobbies or from the customer's letter carrier. Once the form is completed it can be returned to the carrier or dropped in a collection box. Orders are normally returned to the customer within 2 or 3 business days.

STAMPS BY PHONE

Stamps by Phone is a convenient program that is intended to target business, professional, and household customers who are willing to pay a service charge for the convenience of ordering by phone and paying by credit card (VISA or MasterCard) to avoid trips to the Post Office. Customers utilizing this service can call a toll-free number (1–800–STAMPS–24), 24 hours a day, 7 days a week, and order from a menu of postal products. There is no minimum purchase amount and customers receive their orders within 3 to 5 business days.

ALTERNATE POSTAL RELIEF SITES

Alternate postal retail sites including grocery stores and other retail stores that offer stamps for sale through a consignment agreement, and contract postal units that offer a wider variety of serv-

ices. Stamps offered through consignment agreements are sold at no more than face value at retailer checkstands. Contract postal units provide more convenient locations for our customers to mail packages, purchase stamps and postal money orders, send registered mail, and obtain postal services.

In 1998, the U.S. Postal Service began testing a partnership with Mail Boxes Etc. (MBE) to sell stamps and postal services at 250 MBE locations throughout the United States. In 2000, the test partnership expanded to 700 MBE locations. By providing services at numerous alternate locations, the U.S. Postal Service provides greater access and flexibility for all customers to obtain stamps and other postal services, which generally means less wait time to obtain these retail services. This enables customers to combine their mailing needs and other errands into a single trip to the neighborhood shopping center or grocery store, This is especially convenient for our elderly customers who may have limited access to transportation.

STAMPS VIA THE WORLD WIDE WEB

On November 8, 2000, the U.S. Postal Service launched the new Postal Store, an online retail channel. Accessed through our homepage, www.usps.com. The Postal Store offers USPS customers an alternative channel for buying stamps and stamp products without having to visit a physical retail outlet. With just a click of their mouse, customers can browse through "aisles" displaying a variety of stamps, stationery, Pro-Cycling gear and phone cards. To provide ease of use, stamps and other products are organized and displayed according to categories and/or stamp release dates. As an added convenience, credit cards are processed and validated at the time orders was placed. Security is enhanced through the application of the Address Verification System, which verifies a customer's billing address through their credit card company. State-of-the-art order processing and automated fulfillment equipment systems ensure the efficient delivery of orders within 3–5 days.

This convenient, secure, and easy-to-use web site especially benefits customers who, because of special needs, prefer to purchase postal and non-postal products from the comfort of their homes.

STAMPS HIGHLIGHTING AGING ISSUES

On September 7, 2000, the U.S. Postal Service honored the memory and work of former U.S. Senator Claude D. Pepper of Florida by issuing a commemorative stamp bearing his image. The stamp, which is part of the Postal Service's Distinguished Americans stamp series, helped celebrate the life of a man who was known as a champion for the rights of Senior Citizens in his home state of Florida and across the country.

ITEM 23—RAILROAD RETIREMENT BOARD

ANNUAL REPORT ON PROGRAM ACTIVITIES FOR THE ELDERLY

The U.S. Railroad Retirement Board is an independent agency in the executive branch of the Federal Government, administering comprehensive retirement-survivor and unemployment-sickness benefit programs for the nation's railroad workers and their families under the Railroad Retirement and Railroad Unemployment Insurance Acts. The Board also has administrative responsibilities under the Social Security Act for certain benefit payments and railroad workers' Medicare coverage.

Under the Railroad Retirement Act, the Board pays retirement and disability annuities to railroad workers with at least 10 years of service. Beginning in 2002, such annuities are also payable to workers with five years of service if performed after 1995. Full age annuities are payable at age 60 to workers with 30 years of service. For those with less than 30 years of service, reduced annuities are payable at age 62 and unreduced annuities are payable at full retirement age, which is gradually rising from 65 to 67, depending on the year of birth. Disability annuities are payable before retirement age on the basis of total or occupational disability. Annuities are also payable to spouses and divorced spouses of retired workers and to widow(er)s, divorced or remarried widow(er)s, children, and parents of deceased railroad workers. Qualified railroad retirement beneficiaries are covered by Medicare in the same way as social security beneficiaries.

Under the Railroad Unemployment Insurance Act, the Board pays unemployment benefits to railroad workers who are unemployed but ready, willing and able to work and pays sickness benefits to railroad workers who are unable to work because of illness or injury.

BENEFITS AND BENEFICIARIES

During fiscal year 2002, retirement and survivor benefit payments under the Railroad Retirement Act amounted to $8.6 billion, $232 million more than the prior year. The number of beneficiaries on the retirement-survivor rolls on September 30, 2002, totaled 635,900. The majority (83 percent) were age 65 or older.

At the end of the fiscal year, 297,700 retired employees were being paid regular annuities averaging $1,531 a month. Of these retirees, 132,100 were also being paid supplemental railroad retirement annuities averaging $42 a month. In addition, some 151,000 spouses and divorced spouses of retired employees were receiving monthly spouse benefits averaging $579 and, of the 194,900 sur-

vivors on the rolls, nearly 160,500 were aged widow(er)s receiving monthly survivor benefits averaging $948. About 7,700 retired employees were also receiving spouse or survivor benefits based on their spouse's railroad service.

Nearly 578,700 individuals who were receiving or were eligible to receive monthly benefits under the Railroad Retirement Act were covered by hospital insurance under the Medicare program at the end of fiscal year 2002. Of these, 563,800 (97 percent) were also enrolled for supplementary medical insurance.

Gross unemployment and sickness benefits paid under the Railroad Unemployment Insurance Act totaled $137.4 million during fiscal year 2002, while net benefits totaled $98.6 million after adjustments for recoveries of benefit payments, some of which were made in prior years. Total gross and net payments increased by approximately $9.9 million and $3.8 million, respectively, from fiscal year 2001. Unemployment and sickness benefits were paid to 39,500 railroad employees during the fiscal year. However, only about $0.4 million (less than 1 percent) of the benefits went to individuals age 65 or older.

FINANCING

The Board's 22nd triennial actuarial valuation, submitted to Congress in June 2003, was generally favorable. The valuation concluded that, barring a sudden, unanticipated, large drop in railroad employment, or substantial investment losses, the railroad retirement system will experience no cash flow problems during the next 19 years. The long-term stability of the system, however, is not assured. Under the current financing structure, actual levels of railroad employment and investment return over the coming years will determine whether corrective action is necessary.

The Board's 2003 railroad unemployment insurance financial report was also generally favorable, indicating that even as maximum benefit rates increase 44 percent from $52 to $75 from 2002 to 2013, experience-based contribution rates are expected to maintain solvency. No new loans are anticipated even under the most pessimistic assumption. The report also predicted average employer contribution rates well below the maximum throughout the projection period, but there may be a periodic resumption of the surcharge required to maintain a minimum account balance.

No increases in the tax rates provided under current law were recommended by the Board for the railroad retirement or unemployment insurance systems.

LEGISLATION

The Board successfully completed implementation of the Railroad Retirement and Survivors' Improvement Act of 2001. The Act, based on joint recommendations negotiated by a coalition of rail labor organizations and rail freight carriers, was the most significant railroad retirement legislation in almost 20 years and the first in almost three decades not to involve tax increases or benefit reductions.

The legislation, signed into law December 21, 2001, liberalized early retirement benefits for 30-year employees and their spouses, eliminated a cap on monthly retirement and disability benefits,

lowered the minimum service requirement from 10 years to 5–9 years, if at least 5 years were after 1995, and provided increased benefits for some widow(er)s. Financing sections in the law provided for adjustments in the payroll tax rates paid by employers and employees, and the repeal of a supplemental annuity work-hour tax.

The legislation also provided for the transfer of railroad retirement trust funds from the Railroad Retirement Accounts in the U.S. Treasury to a new National Railroad Retirement Investment Trust, whose Board of seven Trustees is empowered to invest Trust assets in nongovernmental assets, such as equities and debt, as well as in governmental securities. During 2002, Trustees and staff were appointed and the Trust officially began operations.

For the Board, implementation of the Act included, among other things, significant changes to over 30 mainframe and PC-based computer systems, the development of new automated mass benefit adjustment operations, and the release of over 255,000 letters. Benefit increases were awarded to over 46,000 widow(er)s and nearly 14,000 employees and spouses.

OFFICIALS

On May 23, 2003, the Senate confirmed President Bush's appointment of Michael S. Schwartz as Chairman of the U.S. Railroad Retirement Board for a term expiring in August 2007. A longtime official with the State of Illinois, Mr. Schwartz previously served as the Director of the Illinois Department of Central Management Services which provides procurement, data processing and communication, personnel, property management, and administration of State employee benefit plans to State and local government agencies.

V. M. Speakman, Jr. continues to serve as Labor Member of the Board. He was first appointed to the Board in 1992, reappointed to a second term of office in 1995, and then to a third term in 2000. Mr. Speakman previously served as President of the Brotherhood of Railroad Signalmen.

Jerome F. Kever continues to serve as Management Member of the Board. He was first appointed to the Board in 1992, reappointed to a second term of office in 1995, and to a third term in 2000. Before his appointment, Mr. Kever was Vice President and Corporate Controller of the former Santa Fe Southern Pacific Corporation.

SERVICE QUALITY MEASUREMENTS

Customer Satisfaction Survey.—In 2001, the Board participated for the first time in the American Customer Satisfaction Index, which surveys national customer satisfaction with corporate and government goods and services. Federal agencies use this survey to gauge their level of service and benchmark their performance for comparison with similar organizations in the private sector. In a 2001 survey focused on the Board's core constituency of recently retired rail workers awarded annuities, the Board earned a score of 82, which was 13 points higher than the overall Federal Government score and 11 points higher than the comparable private sector average. In a 2002 survey focused on railroad workers claiming

railroad unemployment or sickness benefits, the Board earned a score of 75, which was 4.8 points higher than the overall Federal Government score and 3.2 points higher than the comparable private sector average.

Web Site Survey.—The quality of the Board's Internet service was documented in a San Francisco State University survey that ranked the agency's Web site 12th out of 148 Federal government Web sites studied for excellence, as defined by the quality of their site services, help features, navigation, legitimacy, and accessibility. The Board earned a total excellence score of 26, out of a possible 55, only 5 points below the highest score of 31. The survey studied Federal Web sites between January and April of 2002, as part of broader research that analyzes government Web sites in comparison to other public-sector sites, attempting to improve the quality and the services provided to users through government Web sites.

Through the Board's Web site at www.rrb.gov, anyone with Internet access can electronically download selected pamphlets, informational releases, financial reports, and other information on the agency's benefit programs and operations. During 2002, the Web site was enhanced to allow rail employees to view their service records online through a secure PIN password system.

OFFICE OF INSPECTOR GENERAL

During fiscal year 2002, the Board's Office of Inspector General continued its efforts to ensure the integrity of agency programs, to combat fraud, waste and abuse and to ensure the agency provides the highest level of service to its constituents. Thirteen audit and management information reports issued during the year provided agency managers with recommendations for improvement in program operations.

Investigative activities resulted in 53 criminal convictions, 37 indictments and informations, 36 civil judgments and $3,230,000 in recoveries, restitutions, fines, civil damages, penalties and prevention of overpayments.

PUBLIC INFORMATION ACTIVITIES

The Board maintains direct contact with railroad retirement beneficiaries through its field offices located across the country. Field personnel explain benefit rights and responsibilities on an individual basis, assist railroad employees in applying for benefits and answer any questions related to the benefit programs. The Board also relies on railroad labor groups and employers for assistance in keeping railroad personnel informed about its benefit programs.

At informational conferences sponsored by the Labor Member of the Board for railroad labor union officials, Board representatives describe and discuss the benefits available under the railroad retirement-survivor, unemployment-sickness and Medicare programs, and the attendees are provided with comprehensive informational materials. A total of 2,526 railroad labor union officials attended 47 informational conferences held in cities throughout the United States during 2002. In addition, railroad labor unions frequently request that Board representatives speak before their meetings,

seminars and conventions. In 2002, the Labor Member's Office was represented at 10 union gatherings attended by 3,229 railroad labor officials. Field personnel addressed 163 local union meetings with 11,295 members in attendance.

At seminars for railroad executives and managers, Board representatives review programs, financing, and administration, with special emphasis on those areas which require cooperation between railroad and Board offices. During 2002, the Board's Management Member's Office conducted seven seminars for railroad officials. It also conducted pre-retirement counseling seminars attended by railroad employees and their spouses, and benefit update presentations.

The Board continued its Face-to-Face initiative, an effort to engage customers in an ongoing dialogue about improving the agency's customer service.

The Board's headquarters is located at 844 North Rush Street, Chicago, Illinois 60611–2092, phone (312) 751–4500; the agency's Web site is www.rrb.gov. In addition, the Board maintains an Office of Legislative Affairs in Washington, DC as a liaison for dealing with Members of Congress on matters involving the Railroad Retirement and Unemployment Insurance Acts and legislative issues that affect the Board. The Office of Legislative Affairs is located at 1310 G Street, NW, Suite 500, Washington, DC 20005–3004, phone (202) 272–7742.

ITEM 24_SOCIAL SECURITY ADMINISTRATION

Mission

To promote the economic security of the nation's people through compassionate and vigilant leadership in shaping and managing America's Social Security programs.

In 1935, the Social Security Act established a program to help protect aged Americans against the loss of income due to retirement. The program has expanded and matured to become America's largest and most effective safety net for the elderly. Protection for survivors of deceased retirees was added in 1939, thus creating the Old Age and Survivors Insurance (OASI) program. Social Security protection was expanded further in 1956 to include the Disability Insurance (DI) program. The responsibilities of the Social Security Administration (SSA) were further expanded in 1972 to include the Supplemental Security Income (SSI) program, and again in 1999 to include Special Benefits for Certain World War II Veterans (SVB).

During 2001 and 2002, Social Security benefits comprised 39 percent of the aggregate income of the population age 65 and over. While much of the nation's aged population has income from other sources, a portion of the beneficiary population relies heavily on Social Security. For one-third of the beneficiaries, it contributes all or almost all of their income, and for almost two-thirds of the beneficiaries it is their major income source.

SSA is the steward of programs and resources vital to the well-being of the nation's growing aged population. SSA works to ensure that the intended benefits of its programs are received, that the programs it administers and the services it provides are available and accessible in a user-friendly manner, and that it provides information to the elderly and the public that is critical in planning for and protecting the economic security of older Americans. This report describes the programs and services of SSA that benefit and affect the aged and highlights significant activities that were initiated or continued in 2001 and 2002.

I. Overview of the Social Security Programs

A. The OASI Program: To qualify for OASI benefits, a worker must have paid Social Security taxes (Federal Income Contributions Act and/or Self-Employment Contributions Act) and earned 40 credits over the course of his/her lifetime (individuals born before 1929 need fewer credits), which can be done in as few as 10 years. The taxes are deposited into the OASI Trust Fund. Nine out of 10 working Americans can count on benefits when they retire, with reduced benefits payable as early as age 62. Benefits are also paid to eligible members of retired workers' families and survivors.

The percentage of pre-retirement (career-average) earnings replaced by Social Security benefits for a retired worker varies because the benefit formula is weighted in favor of workers with lower earnings.

B. The DI Program: Disability benefits are paid from the DI Trust Fund derived from workers' payroll taxes. They provide a continuing income base for eligible workers who have qualifying disabilities and for eligible members of their families. To qualify for DI benefits, an individual must be insured and must have substantial recent covered work experience before becoming disabled. Workers are considered disabled if they have a medically determinable physical or mental impairment that prevents them from engaging in substantial gainful activity. The disability must be expected to last for a continuous period of at least 12 months or to result in death. About 9 out of 10 people ages 21 through 64 who worked in covered employment in 2001 can count on receiving benefits if they become disabled.

Once benefits begin, they continue for as long as the worker meets the DI program requirements. SSA conducts continuing disability reviews to periodically determine if the worker remains disabled. The Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170) created additional incentives for certain disability recipients to return to work.

C. The SSI Program: SSI is a cash assistance program designed to assure a minimum level of income to individuals who are aged, blind or disabled and have limited income and resources. SSI payments and administrative expenses are financed from general tax revenues, not the Social Security trust funds. Qualified recipients receive monthly cash payments to raise their income to the amount guaranteed by the SSI program. Disability or blindness benefits are available regardless of age, while aged benefits are available only to persons 65 or older. The definition of disability for individuals 18 or older in the SSI program is the same as in the DI program. There is a separate definition of disability for children applying for SSI benefits. There are incentives that encourage SSI recipients to work. The Federal benefit rate and eligibility requirements are uniform nationwide. The amount of a person's income is used to determine both eligibility for and amount of SSI benefits.

Social Security beneficiaries may qualify for SSI payments if they meet SSI income and resource eligibility requirements and are either age 65 or older, blind or disabled. In September 2002, Social Security benefits were received by 35.9 percent of all SSI recipients. SSI aged recipients are more likely (58.2 percent) to be receiving Social Security benefits than SSI blind and disabled recipients (30.8 percent).

In 2002, SSA continued to build on improvements in its management of SSI, such as improving our identification and collection of SSI debt and issuing a comprehensive "SSI Corrective Action Plan." The SSI program was removed from the Comptroller General's "high risk" list.

D. SVB: Special Benefits for Certain World War II Veterans, known as Special Veterans Benefits (SVB), were provided for in The Foster Care Independence Act of 1999 (P.L. 106-169), which was enacted on December 14, 1999. This statute, which created title VIII of the Social Security Act, provides a monthly cash payment to certain World War II veterans. To qualify, these veterans must have been eligible for SSI in both December

1999 and the month in which he or she filed an application for the special benefits and who resided outside of the 50 states, the District of Columbia and the Northern Mariana Islands. General tax revenues are used to reimburse the Social Security trust funds for SSA's cost of administering the SVB program.

Implementing the SVB program posed significant challenges in the areas of policy, operations, systems and financial management. Despite these challenges, SSA began paying SVB in May 2000, five months before the date required by the legislation.

II. Impact of Social Security Programs on the Economic Security of the Aged

A. OASI Benefits and Beneficiaries: Ninety-one percent of individuals age 65 and older were receiving OASI benefits in 2001 and 2002. The vast majority of beneficiaries in this age group are retired workers. Monthly benefit amounts to which an individual (or eligible dependents) may become entitled under the OASI program are based on the individual's taxable earnings during his or her lifetime. The maximum amount of earnings on which Social Security taxes were payable in 2001 was $80,400 and increased to $84,900 in 2002.

As of December 31, 2001, there was a total of 38,964,222 OASI beneficiaries who received a total of $372.4 billion in benefits. As of December 31, 2002, the total number of beneficiaries was 39,223,028 and the total amount of benefits was $388.2 billion. Over 95 percent of the OASI benefits paid in both years were to aged beneficiaries.

In 2001, an additional 2,561,480 retired workers, their eligible spouses and certain aged survivors became entitled to payments from the OASI Trust Fund. OASI benefits are automatically adjusted based on the Consumer Price Index (CPI) once a year. The average monthly benefit amounts at the end of 2001, during which there was a 3.5 percent increase based on the CPI, were $874 for retired workers, $443 for eligible spouses, $841 for aged widow(er)s and $729 for dependent parents. In 2002, the number of additional retired workers, their eligible spouses and certain aged survivors that became entitled to OASI benefits was 2,627,461. The average monthly benefit amounts at the end of 2002, during which the CPI increase was 2.6 percent, were $895 for retired workers, $451 for eligible spouses, $861 for aged widow(er)s and $753 for dependent parents.

B. SSI Payments and Recipients: SSI payment levels, like OASI benefit amounts, are adjusted based on the CPI. In 2001, when the CPI increase was 3.5 percent, the maximum monthly Federal SSI payment level for an individual was $531. The maximum monthly payment for an eligible married couple was $796. In 2002, there was a 2.6 percent increase in the CPI, which increased SSI payment levels to $545 for an individual and $817 for an eligible couple.

C. SVB and Beneficiaries: Qualified veterans receive a monthly SVB equal to 75 percent of the current SSI Federal payment rate less the amount of any recurring pension income for the month. There is no provision for payments to dependents or survivors.

An estimated 3,000 veterans will eventually be eligible for federally funded SVB benefits, almost all of whom are Filipino veterans residing in the Philippines. In December 2001, SVB payments were made to 2,015 beneficiaries. In December 2002, SVB payments were made to 2,404 beneficiaries. SVB payments may also include federally administered State of California funds.

Economic Impact of Social Security Programs on the Aged

Impact / Program	Approximate Amounts Paid		# of Aged Recipients	
	2001	**2002**	**2001**	**2002**
OASI[1]	$353.8 billion	$368.8 billion	36,205,384	36,436,970
SSI[2]	$7.3 billion	$7.6 billion	1,995,159	1,995,284
SVB	$7.6 million	$9.2 million	2,015	2,404

[1] Restricted to retired workers, eligible spouses, aged widow(er)s, and dependent parents of deceased workers.
[2] Represents all SSI recipients age 65 or older who received Federally-administered SSI payments, including State supplementation.

III. Support to Other Programs that Affect the Aged

In addition to its basic programs, SSA also provides administrative support to other programs that affect the aged, particularly Black Lung, Medicare, Medicaid, Railroad Retirement and Food Stamps.

A. Black Lung Program: The Black Lung (BL) program pays monthly cash benefits to coal mine workers and their dependents and survivors. During most of the time period covered by the 107th Congress, SSA was fully responsible for administering Part B of the BL program under title IV of the Federal Coal Mine Health and Safety Act (P.L. 91-173). Part B covers claims filed by miners before July 1973 and survivor claims filed before January 1974 or within 6 months of the death of a miner or widow(er) who was receiving Social Security benefits, whichever is later. Any claims filed after these dates generally are covered under Part C of the BL program and are the responsibility of the Department of Labor (DOL). SSA is also responsible for taking claims for and performing certain other services related to Part C benefits.

In September 1997, SSA negotiated an agreement with DOL under which DOL handled most of SSA's Part B work on a reimbursable basis. Under the agreement, SSA remained responsible for programmatic policy and for processing any BL cases that were appealed to an Administrative Law Judge (ALJ) or to the Appeals Council. DOL became responsible for all payment and administrative services for the Part B cases.

In late 2002, full responsibility for the Part B of the BL program was given to DOL by the Black Lung Consolidation of Administrative Responsibility Act (P.L. 107-275), which was signed on November 2, 2002. Administrative actions are currently underway between DOL and SSA to transfer all aspects of the Part B program to DOL.

In 2001, 86,340 beneficiaries received approximately $482 million in Part B benefits; and in 2002, 78,806 Part B beneficiaries received approximately $448 million. In FY 2002, SSA field offices took 467 claims for Part C benefits and transferred them to DOL for payment as required by law. SSA was reimbursed by DOL for these services.

B. Medicare: SSA performs certain functions for the Medicare program under agreements with the Secretary of Health and Human Services (HHS). Social Security offices process applications for entitlement to and requests for disenrollment from Medicare, assist individuals with questions regarding Medicare benefits, process requests for replacement Medicare cards, maintain the computerized records of Medicare eligibility, and withhold Medicare premiums from Social Security payments. SSA's Office of Hearings and Appeals (OHA) adjudicates coverage, eligibility and enrollment appeals. SSA devotes over 1,500 work years annually in support of the Medicare program and receives funding from the Centers for Medicare & Medicaid Services (CMS) for these activities.

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (P.L. 106-554), which was signed on December 21, 2000, made major changes to the Medicare appeals process and created a new right to challenge Medicare coverage policies issued by Medicare contractors. Implementation of most of the changes made by BIPA has been delayed pending issuance of final regulations by HHS.

Overall Federal administrative responsibility for the Medicare program rests with CMS in HHS. Discussions between SSA and HHS to transfer responsibility for the Medicare hearings function from OHA to CMS are ongoing. Several pieces of legislation introduced in the 107th Congress called for such a transfer to take place, although none were enacted into law.

C. Medicaid: In 32 states and the District of Columbia, eligibility for SSI confers automatic entitlement to Medicaid. Thus, the SSI eligibility determination made by SSA saves a significant number of work years for these states. SSA also provides information and referral services in support of Medicaid and receives funding from the states and CMS for these activities.

D. Railroad Retirement: SSA provides services in connection with entitlement to benefits from the Railroad Retirement Board (RRB). SSA takes the applications, determines jurisdiction and coordinates benefit payments with the RRB. As required by statute, RRB issues a combined monthly benefit payment when a retiree has both Railroad and Social Security covered work and is therefore entitled to both benefits. SSA reimburses the RRB for OASI and DI benefits paid on its behalf. In addition, SSA

arranges an annual financial interchange with the Railroad Retirement Trust Fund to place the Social Security trust funds in the same position they would have been in had railroad employment been covered by Social Security.

E. Food Stamps: SSA assists the Department of Agriculture by providing information about the food stamp program and by taking food stamp applications from qualified OASI, DI and SSI claimants.

While SSA does not have primary responsibility for the BL, Medicare, Medicaid, Railroad Retirement or Food Stamp programs, SSA's role in support of and in coordination with these programs facilitates the receipt of benefits or services that contribute to the economic security of the aged.

IV. Service Delivery to the Aged

A. Improving Access: SSA is committed to making its services and programs readily accessible to the aged. In 2001 and 2002, SSA continued to expand and facilitate access through the use of technology to supplement the in-person access available at its 1,300-plus field offices. SSA also continued to provide access to beneficiaries with language barriers.

1. 800 Number/Immediate Claims Taking Units (ICTUs): SSA has operated a national 800 number since 1988. The 800 number, which is answered at one of SSA's 38 Teleservice Centers (TSCs), provides callers, particularly the aged, an easy opportunity to ask questions about eligibility or benefits for any program SSA administers or supports.

Calls to the 800 number frequently relate to filing for benefits. To expand and improve access, SSA established ICTUs. When a caller contacts a TSC to inquire about filing for benefits, a representative will determine if the caller meets all of the eligibility requirements to file for retirement, Medicare, spouse's, widow(er)'s, lump-sum death or student benefits. If the requirements are met, the representative will refer the caller to one of the 14 ICTU sites where he/she can file an application by telephone. This makes applying for benefits much easier and eliminates the need to visit a field office or to wait for an appointment to file an application for benefits.

In FY 2002, the 800 number received approximately 51 million calls. Almost one-third of those (32.9 percent) related to retirement benefits, over three-quarters (76.3 percent) of which were processed to completion on the 800 number. The percentage of calls related to Medicare was 7.3, of which 91.4 percent were processed to completion.

In a survey of satisfaction with the 800 number for FY 2003, 86 percent of callers gave an overall rating of excellent, very good or good.

In FY 2002, the ICTUs processed 375,423 claims and in FY 2003, the ICTUs processed 434,878 claims, the vast majority of which were filed by the aged.

2. www.socialsecurity.gov: Our website provides a wealth of information on Social Security programs, with a special emphasis on areas of interest to the aged. The website includes a Retirement Planner and benefit calculators; provides online filing for retirement, spouse's, and disability benefits; accepts online requests for replacement Medicare cards and Form 1099s; allows beneficiaries to obtain benefit verification letters; enables beneficiaries to review and/or change their address and direct deposit information; enables the public to request an earnings statement; and contains links to numerous other websites that offer information of interest to the aged. The website is also an easy way to contact SSA electronically with questions, complaints or compliments and receive a response via electronic mail.

In mid-2001, with the needs of the aged in mind, SSA completely redesigned its website, focus testing several prototypes and inviting the aged to "usability test" the final versions. As a result, the website is:

- Easier to use - the website and its individual pages are organized around common life events (retirement, death of a spouse, etc.) so that visitors, especially the aged, can easily find what they are looking for;
- More attractive, with a consistent look on every page - a reassuring feature for visitors such as the aged who might not be frequent Web users; and
- Accessible to all visitors - screen readers used by the aged and the visually impaired, and devices used by people with other physical impairments, operates on the website.

To inform the aged about our new and improved website, SSA:

- Alerted advocacy groups that the website is "508 compliant" (easy-to-use for the aged, the visually impaired, and other physically disabled people),
- Arranged for aged-oriented organizations (e.g., AARP, FirstGov for Seniors, etc.) to link to SSA from their websites,
- Educated SSA employees so they would be able to promote the website not only to the aged visiting field offices, but also in their personal dealings,
- Provided local Social Security managers with Online Services Talking Points to use when speaking with groups,
- Included our website address on all Social Security publications,
- Created a special edition of *eNews*, SSA's award-winning online newsletter, for the aged, and
- Promoted our Online Services in the "on-hold" message the aged may hear when they call our 800 number.

The Internet has made providing service to the aged easier and quicker for them and for SSA. In November 2000, SSA began accepting retirement claims via the Internet.

The number of claims taken in FY 2001 was 77,853. In FY 2002, the total was 112,013, and in FY 2003 it was 103,232.

3. Interpreter/Translator Services: SSA is committed to providing fair and equitable service to the public, including the aged, regardless of an individual's ability to communicate effectively in English. Accordingly, SSA recognizes that using qualified interpreters facilitates its processes, deters fraud and assures that individuals with limited English proficiency (LEP) are not disadvantaged.

In terms of direct service, this commitment is generally accomplished by having bilingual staff available to conduct interviews and otherwise assist LEP claimants. When bilingual staff is not available, SSA provides an interpreter free of charge to any individual requesting language assistance or when it is evident that such assistance is necessary to ensure that the individual is not disadvantaged.

In addition, SSA strives to ensure maximum accessibility of all SSA programs and proceedings to deaf and hearing impaired persons. Therefore, SSA provides sign language interpreter services whenever necessary to ensure accurate communication.

In 2000, 32 percent of SSI aged applicants required an interpreter or translator. In 2001, that number rose to 34 percent and remained at that level for 2002.

B. Special Initiatives for the Aged

1. Notice to Widow(er)s who are Potentially Eligible for Higher Retirement Benefits: As part of SSA's ongoing effort to ensure that retired workers receive the highest cash benefit to which they are entitled, notices are sent to widow(er)s advising them that they may be eligible for a higher benefit on their own account. Approximately 54,000 notices were mailed in 2001 and 53,000 in 2002. Historically, upwards of 80 percent of the notices resulted in higher cash benefits.

2. Consideration of Language Barrier in Determining Eligibility for SSI-Qualified Aliens: The Balanced Budget Act of 1997 (P.L. 105-33) amended The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) and added additional alien eligibility criteria. The new criteria allow individuals to establish eligibility to SSI based on disability even after attainment of age 65.

Social Security Ruling 99-3p expanded the policy interpretation to include illiteracy in English or the inability to communicate in English as a factor in making disability determinations. This ruling continues to make eligibility to SSI disability possible for individuals over age 65 whose limited proficiency in English would further reduce the number of available vocational options.

3. Elimination of Annual Earnings Test: The Senior Citizens' Freedom to Work Act of 2000 (P.L. 106-182) eliminated the Social Security annual earnings test beginning with the month in which a person attains full retirement age. SSA

undertook an extensive public information campaign to let the public know about the new legislation. As a result of pre-planning, SSA mailed over 9 million notices within 90 days of enactment informing retired workers that their benefits would not be offset because of other earnings. Some beneficiaries who work were due retroactive benefits because the law was effective January 1, 2000. At the time the law was passed, SSA anticipated that approximately 800,000 beneficiaries ages 65 through 69 who were working or the dependents of workers would be affected. Approximately another 100,000 beneficiaries in the same age range would be affected when they filed a claim for benefits. Beneficiaries who have attained full retirement age and who have earnings are no longer disadvantaged by continuing to work.

C. Outreach Activities: In addition to its basic programs, SSA also provides a significant measure of service delivery support for the Medicare and Food Stamp programs.

1. Medicare: SSA is the primary public point of contact for the Medicare program, providing key support to CMS. SSA staff answers questions about and determine Medicare eligibility. Medicare beneficiaries can also obtain pamphlets, brochures and other publications about Medicare benefits in SSA field offices and via the 800 number. Funding for these services comes from the Medicare trust funds.

The Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act of 2002 (P.L. 107-116), which was signed on January 10, 2002, earmarked $7 million to fund SSA's outreach program to notify potentially eligible beneficiaries, especially the aged, of programs designed to assist with Medicare cost-sharing. SSA used its records to identify beneficiaries potentially eligible for the Medicare Savings Program and mailed over 16 million notices to Medicare beneficiaries in all 50 states and the District of Columbia. In addition, SSA shares the list of potentially eligible beneficiaries with State Medicaid agencies. Those agencies use the information to decide whether they should pay some or all of a qualified Medicare beneficiary's monthly premiums for Part A and/or Part B.

2. Food Stamps: All SSA field offices have posters, leaflets and fact sheets regarding the food stamp program on premises to help reach all potentially eligible applicants, especially the aged. SSA also takes food stamp applications for qualified OASI, DI and SSI claimants.

The Farm Security and Rural Investment Act of 2002 (P.L. 107-171), which was signed on May 13, 2002, provided funding for FYs 2003 through 2007 for access and outreach projects for States to improve the process of applying for food stamps, SSI, Medicaid and other benefit programs, and for coordinating application to and eligibility for such programs.

In December 2002, the Food and Nutrition Service (FNS) and SSA signed a Memorandum of Understanding to begin work over the coming years on expanding the number of states operating Combined Application Project (CAP) demonstrations.

The "standard" CAP demonstration is a joint FNS-SSA demonstration project that tests streamlined procedures for providing food stamp benefits to one-person households eligible for both food stamps and SSI. These projects are currently operating in three states -- South Carolina, Mississippi and Washington -- with additional sites planned.

In FY 2002, SSA processed 39,775 food stamp applications and recertifications.

V. Communications and Publications

SSA's national public information activities are aimed at more than 46 million Social Security beneficiaries, more than 6 million SSI recipients and over 190 million workers currently paying into the Social Security trust funds. SSA wants to ensure that current and future beneficiaries are aware of its programs and services, and their rights and responsibilities.

A. Communications Activities: SSA cultivates and maintains effective working relationships with a wide range of national organizations and advocacy groups to conduct collaborative outreach activities. In 2001 and 2002, SSA continued its outreach activities to the aged that included a concentrated effort to:

- Participate in and staff exhibit booths at numerous conferences and workshops sponsored by national organizations including AARP, American Health Care Association, Alliance for Retired Americans and American Association of Homes and Services for the Aging where Social Security information was provided and questions were answered;
- Participate in meetings organized by various national organizations such as AARP, National Council on the Aging, National Academy of Social Insurance, National Association for Area Agencies on Aging, the Older Women's League, the Leadership Council of Aging Organizations;
- Attend legislative meetings, briefings and forums to discuss funding for aging programs, global aging and public policy updates;
- Distribute a wide range of Social Security publications;
- Demonstrate online services; and
- Arrange Social Security presenters at numerous meetings and forums.

The above activities were enhanced and expanded over this period because of SSA's commitment to engage the aged in Social Security issues and its ongoing working relationships with the organizations representing this audience.

B. The *Social Security Statement:* The *Social Security Statement* is the "flagship" of Social Security's printed messages to the public. Its primary goal is to provide workers with personal information, such as their earnings record and benefit estimates, to help them plan their financial future and, ultimately, their retirement. The *Statements* are issued in English or in Spanish, depending on the recipient's preference.

In 2001, *Statements* were sent to 135,624,325 and in 2002 that number increased to 137,998,121. Recipients who are age 55 or older also receive a retirement option insert entitled "Thinking of Retiring? Consider Your Options," which is intended to guide them in deciding when the best time is for them to begin receiving Social Security benefits. In 2001, 20,231,478 people received the insert and in 2002, the insert went to 21,563,771 people.

C. Solvency: SSA's Office of the Chief Actuary has responsibility for estimating the balance between future benefit obligations and future tax collections, and assessing the programs' financial status. These estimates are presented in the Social Security Board of Trustees Annual Report to the Congress, the Budget of the United States Government, the Commissioner's Annual Report on SSI and the Annual Financial Reports of the Social Security Administration and the Federal Government. In addition, SSA's actuaries evaluate the financial effects of proposals of the Administration, Congress and others to change the OASI, DI and SSI programs and monitor the programs' financial operations. In 2002, the Office of the Chief Actuary established a website that can be found at www.socialsecurity.gov/OACT/solvency/index.html containing publications on comprehensive long range solvency proposals.

D. Other Publications: As part of its ongoing commitment to keep the public, especially the aged, informed and aware of its programs, SSA issues more than 140 publications that provide information about the Social Security program, as well as the availability of benefits and how to apply for those benefits.

These publications relate to programs that are available to persons of all ages: OASI, DI and SSI and beneficiaries' rights and responsibilities. Some publications provide information on all of the programs, such as "Social Security: What Every Woman Should Know." Others address specific issues of particular interest to the aged, including "What You Need to Know When You Get Retirement or Survivors Insurance" and "Medicare." The publications are updated each year to provide the latest information.

VI. Summary of Social Security-Related Legislation Affecting the Aged Enacted during the 107th Congress

A. P.L. 107-90 (HR 10), Railroad Retirement and Survivors Improvement Act of 2001, signed on December 21, 2001

Provides for Social Security benefits to be certified for payment by the RRB on the records of workers with either 10 years of service covered under the Railroad Retirement Act or 5 years of such covered service accrued after December 31, 1995.

B. P.L. 107-116 (HR 3061), Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 2002, signed on January 10, 2002

Appropriated funds not obligated as of the end of FY 2001 are available to continue the evaluation of SSA's demonstration projects to promote Medicare buy-in programs. The description of the conference agreement also provides that $7 million of the funds appropriated for the SSI program are to be used for outreach efforts under section 1144 of the Social Security Act to identify individuals who may be eligible for Medicare cost-sharing under the Medicaid program.

C. P.L. 107-171 (HR 2626), Farm Security and Rural Investment Act of 2002, signed on May 13, 2002

Provides Federal funding of up to $5 million for each FY 2003-2007 for access and outreach projects for states to improve the process of applying for food stamps, SSI, Medicaid, SCHIP and other benefit programs, and for coordinating application and eligibility determination processes for such programs. In addition, it provides food stamp eligibility to any otherwise eligible qualified aliens who have continuously resided in the United States for 5 years or more and is effective April 1, 2003.

D. P.L. 107-275 (HR 5542), Black Lung Consolidation of Administrative Responsibility Act, signed on November 2, 2002.

Provides that the Commissioner of Social Security shall transfer to the Secretary of Labor the function and all property and records, as approved by the Office of Management and Budget, that relate to the Part B BL program, except for those instances in which proceedings are currently pending before an ALJ, the Appeals Council or are pending judicial review. The law was effective 90 days after the date of enactment.

ITEM 25—DEPARTMENT OF VETERANS AFFAIRS

I. INTRODUCTION

The Department of Veterans Affairs (VA) has the potential responsibility for a beneficiary population of over 25 million veterans. The median age of veterans is approximately 59 years old compared to a median age of approximately 36 years old for the general U.S. population. About 38 percent (or more than 9 million) of the veteran population is age 65 and older. By the year 2005, about 4.9 million veterans will be 75 years or older. As of September 30, 2002, over 6 million veterans were enrolled in VA for health care. Of these, 2.3 million (47.3 percent) were 65 and older.

This demographic trend will require VA to redistribute its resources to meet the different needs of this older population. Historically, older persons are greater users of health care services. The number of physician visits, short-term hospital stays, and number of days in the hospital, as well as the need for long-term care services, all increase as the patient moves from the fifth to seventh decade of life.

VA has developed a wide range of services to provide care in a variety of institutional, non-institutional, and community settings to ensure that the medical, psychiatric and socioeconomic needs of the patient are met. Special projects, a variety of innovative, medically-proven programs and individual VA facility initiatives have been developed and tested that can be used for veteran patients and adapted for use by the general population.

VA operates the largest health care system in the Nation, encompassing 163 hospitals, 135 nursing home care units, 43 domiciliaries, 75 home care programs and over 800 outpatient clinics. VA also contracts for care in non-VA hospitals, community nursing homes, adult day health care centers, and provides fee-for-service visits by non-VA home health care providers. In addition, VA supports care in the State Veterans Home Per Diem Grant Program for 114 programs that include: hospitals, nursing homes, domiciliaries and an adult day healthcare center in 46 States and Puerto Rico in FY 2002. As part of a broader VA and non-VA network, affiliation agreements exist between virtually all VA health care facilities and nearly 1,000 medical, dental, and associated health schools. This affiliation program with academic health centers results in approximately 91,000 health professions students receiving education and training in VA Medical Centers each year.

In addition to VA hospital, nursing home and domiciliary care programs, VA is increasing the number and diversity of non-institutional extended care programs. The dual purpose is to facilitate independent living and to keep the patient in a community setting by making available the appropriate supportive medical and health

care services. These programs include Home-Based Primary Care (HBPC), Community Home Health Care (CHHC), Community Residential Care (CRC), Adult Day Health Care (ADHC), Psychiatric Day Treatment and Mental Hygiene Clinics, Geriatric Clinics, Homemaker/Home Health Aide (H/HHA) Services, and Hospice/Palliative Care.

The Veterans Millennium Healthcare and Benefits Act, Public Law 106–117, November 1999, mandated nursing home care for veterans 70 percent service-connected and above and for veterans needing nursing home care for a service-connected disability. The Act also expanded veterans' access to a continuum of geriatric and extended care, including home and community based services, and provided authority for VA to conduct one Assisted Living (AL) Pilot Demonstration and three pilot demonstrations comparing different models of All-Inclusive Care (AIC) for the Elderly. In December 2000, the pilot sites for these 3-year demonstrations were selected after competitive review. The AIC sites began enrolling veterans in July 2001 and the AL pilot began enrollment in January 2002.

The need for both acute hospitalization and chronic care management will continue to rise as older patients experience a greater frequency and severity of illness, as well as a different mix of diseases, than younger patients. Cardiovascular diseases, chronic lung diseases, cancers, psychiatric and mental disorders, bone and joint diseases, hearing and vision disorders, and a variety of other illnesses and disabilities are all more prevalent in those persons age 65 and older. VA continues efforts to improve the outcomes of care for elderly patients with complex problems by supporting Geriatric Research, Education and Clinical Centers (GRECCs) and specialized clinical services such as Geriatric Evaluation and Management (GEM), Geriatric Primary Care, and programs for patients with Alzheimer's disease.

II. VETERANS HEALTH ADMINISTRATION

A. Office of Patient Care Services

The Office of Patient Care Services comprises thirteen strategic healthcare groups. Each of these functional groups has contributed significantly to VA's efforts on behalf of older veterans.

Primary and Ambulatory Care Strategic Healthcare Group (SHG)

The Primary and Ambulatory Care SHG and the Geriatrics and Extended Care SHG continue to maximize collaboration in transforming the veterans health care system from a bed-based, hospital inpatient system to one rooted in outpatient service delivery, including delivery of healthcare in the home setting through a combination of telecommunications and direct contact. The Primary and Ambulatory Care SHG has continued to focus efforts on truly delivering primary care to all veterans choosing to access VHA for their healthcare. Issues of productivity, panel identification, panel management, healthcare access and healthcare quality remain in the forefront of efforts. The duality of geriatrics practice, functioning as primary clinician for some elderly veterans and consultant clinician for others, and the challenges of properly identifying the relationship of provider and patient in a given interaction due

to ramifications for continuity, access, quality, and billing among others was a key area that was clarified during 2002. Excellent publications, including those from the Institute of Medicine, point out the distinct advantages to the patient and to a healthcare system when healthcare is provided through primary care. Continuity with the same primary clinician and supporting team regardless of the physical location in which the veteran finds him or herself, access to the clinician and team, coordination of service delivery across loci and specialties, and provision of comprehensive health services remain extremely important parameters of primary care. Given the geographic dispersion of elderly veterans, as well as the economic and supply factors preventing any healthcare system in the United States placing geriatric specialty teams in every small town, both the Primary Care and Geriatric SHGs have provided models and training designed to increase the knowledge and awareness base of smaller practices, often located in Community Based Outpatient Clinics (CBOCs), as well as to improve the communication speed and quality between primary clinicians at any location and geriatric specialists supporting them. Work was underway in 2002 to develop a model of primary care which incorporated a geriatrician in dual role of consultant and primary into a general medicine primary care practice.

The Integrated Ambulatory Care Conference was not held in 2002 due to travel budget restraints. In prior years, this conference provided a national forum, attended by over 500 healthcare managers and providers at many levels and from many professions, in which health care models, field experiments and innovations enhancing access, quality, and productivity were examined and refined. In addition, the meeting furthered interaction and integration of service delivery by focusing on patient needs rather than program needs. In lieu of separate meetings by Women's Health, Mental Health, Geriatrics, Primary Care, and Prevention among others, all of these program offices designed a cooperative and collegial environment where stove piping of services was systematically dismantled. This effort recognized that veterans are not static, do not have a single diagnosis, and that the young veteran with mental health issues today also today has a need for preventive and medical services (and increasingly may be female), and may very well live to be considered geriatric.

Acute Care Strategic Healthcare Group (SHG)

The Acute Care Strategic Health Care Group (ACSHG) serves the elderly veteran in a variety of ways. In FY 2001, 54 percent of the patients on inpatient medical services and 47 percent on inpatient surgical services were over 65. This age group accounted for 58 percent of Intensive Care Unit (ICU) days and 50 percent of Outpatient Care (OPC) surgery. The ACSHG continues to serve as the primary source of physicians trained in medical specialities for the care of all veterans, including the elderly. Elderly patients tend to have move complex medical problems and require more frequent hospitalizations than other age groups. It is necessary that acute care services continue to be available and adequately staffed to meet these demands. This is particularly true in medical specialty areas such as cardiology, pulmonology, endocrinology,

rheumatology, oncology and the surgical specialty areas of urology, cardiothoracic, vascular, and orthopedic surgery. Primary Care physicians on a general medicine ward can handle most medical problems afflicting the geriatric patient; however, there is also a need for areas such as Geriatric Medicine within the acute hospital setting to provide the specialized care needed by the complex geriatric patient. These Geriatric Medicine Sections not only emphasize clinical care, but also coordinate research and education efforts related to geriatrics. The integration of Primary Care within Acute and Ambulatory Care will facilitate a smoother transition for the elderly patient from outpatient to inpatient care as the need arises.

Geriatric Primary Care Education Program

The Employee Education System, Northport Center, sponsored a national conference for the purpose of providing an integrated Geriatric Primary Care Education Program that would allow each VHA Network to develop and implement a Geriatric Primary Care model. The emphasis was on continuity of care, care management, and assessment/triage, based on an interdisciplinary approach. The conference also provided a forum for discussion of a variety of successful VA and non-VA Geriatric Primary Care models of care.

Conference participants included a multidisciplinary team composed of a geriatrician and various primary care providers (physician, physician assistant, nurse practitioner, clinical nurse specialist and social worker) from each Network. In addition, the Northport Center purchased Geriatric Assessment Pocket Guides developed by the Sepulveda VA GRECC and Geriatric Pocket Pals, a reference guide developed by VA, for all conference participants and for each VA facility.

The Employee Education System, Northport Center, will continue to coordinate the activities of VHA's National Primary and Ambulatory Care Education. The Northport Center, in collaboration with Primary and Ambulatory Care, Geriatrics and Extended Care and Mental Health, is planning to present a Strategic Integration Conference in 2003.

Dentistry

Oral/dental care for the geriatric patient involves the prevention of oral disease, the restoration of the dentition and the elimination of pain and suffering attributable to oral disease. Microorganisms originating in the mouth have been identified as potentially causative agents for life-threatening infections of the heart, brain, lung, kidney, spine, and joints. A growing body of evidence, much of it derived from longitudinal studies at VA facilities, suggests associations between chronic periodontal disease and cardiovascular disease and diabetes.

Oral cancer is a disabling, disfiguring and potentially fatal disease that primarily affects middle-aged and older adults. Tobacco and alcohol are important risk factors in the development of this disease, and incidence rates increase steadily with age. In the United States, the five-year survival rate for oral and pharyngeal cancer is approximately 50 percent. Through a long-standing program of oral screening examinations, VA dentists have been able

to expeditiously detect incipient oral cancers in veterans. Such interventions minimize mortality rates and the need for ablative surgery, which often results in severe disfigurement and functional difficulties in eating, speaking, and swallowing.

Mastication of a variety of foods is important for daily maintenance of caloric and nutritive intake, as well as for support of convalescence after surgery, chemotherapy, or other significant health care interventions. Elimination of the causes of oral pain and replacement of missing oral structures work to enhance the amount and diversity of foods that can be eaten. Interpersonal skills are enhanced by preserving or properly restoring teeth in order to maintain clarity of speech and facial contour. A comfortable, functional and esthetic dentition contributes substantially to quality of life.

Destruction of tissues due to dental caries and the periodontal diseases are chronic and, in the elderly, usually asymptomatic. For this reason, public and private health care payers may perceive oral health care directed at dental and periodontal diseases as a low priority or even a luxury. In older patients, dental and periodontal diseases are often aggravated by coexistent medical problems; the oral disease in turn contributes to systemic illness, and in this way drives up health care costs. The relatively minor expense associated with preventive dentistry thus represents a net savings in overall health costs. Preventive modalities include the use of home-applied fluoride solutions, anti-microbial mouth rinses, specially fabricated toothbrushes, instruction to patients, family or caregivers on oral hygiene techniques, and more frequent dental examinations.

Many VA facilities have a Geriatric Evaluation and Management (GEM) Program. The goals for all disciplines involved in GEM—to maximize function and to foster independence—are reflected in dentistry's goals for elderly veterans.

Patients are rehabilitated more rapidly with properly staged and coordinated care. To that end, dental services contribute to the interdisciplinary team effort by conducting admission oral assessments, collaborating on treatment planning, providing specialty consultations and necessary care, and preparing summaries of oral care protocols to be maintained after discharge. The VA Program Guide, "Oral Health Guidelines for Long-Term Care Patients," developed by the Offices of Patient Care Services, the Office of Dentistry, and the Office of Geriatrics and Extended Care, continues to serve as the primary handbook for management of the geriatric oral health efforts. It describes the goals and strategies for implementation and monitoring of oral care provision for patients in VA long-term care programs.

VA dentistry is an undisputed leader in geriatric oral healthcare training. VA-trained geriatric dentists have appointments on a majority of the dental school faculties in the United States. More than one fourth of all hospital-based general dentistry post-graduate education takes place in VA medical centers, where the residents devote much of their educational efforts to the clinical management of older veterans. GEMs and VA nursing homes provide resident training sites that are rich with experience in treating the most complex of older patients.

The impact of VA programs in geriatric dentistry is not limited to VA's health care system, but extends to a broader level. VA dentistry is represented on National Institute of Dental Research reviews, a U.S. Surgeon General's workshop on oral health promotion and disease prevention, the development of the first Surgeon General's Report on Oral Health, and on review panels for programs in medical and dental geriatric education funded by the Department of Health and Human Services, Health Resources and Services Administration.

VA dentists are and have been long involved at the highest levels of leadership in the professional organizations most heavily concerned with oral care issues for older adults (American Society for Geriatric Dentistry, American Association of Hospital Dentists, Federation of Special Care Organizations in Dentistry, American College of Prosthodontists, American Association for Dental Research, Gerontological Society of America). The American Dental Education Association (ADEA) developed guidelines for teaching concepts in gerontology and geriatrics to dental and dental hygiene students, and VA dentists have been noteworthy contributors to this process of defining geriatric educational objectives and identify source materials for dental faculty members.

VA dentists have been leaders and active participants in recent projects involving health services and basic research relevant to the older adult. One investigator has developed measures to assess the relationship between oral health and overall quality of life in older patients. Longitudinal studies of older veterans in Massachusetts and Michigan have yielded a wealth of knowledge on the relationships between age, systemic disease, oral diseases, and diet. VA researchers have surveyed VA dental services to determine the effectiveness of smoking cessation interventions; others have investigated the education of both dental and non-dental health providers with respect to oral cancer risk factors and screening.

Multicenter longitudinal clinical studies through VA have examined the efficacy of metal, ceramic, and ceramo-metal crowns. Another VA cooperative study has amassed the largest database in the world on the emerging alternative to toothlessness, osseointegrated implants, and the factors that predict their successful implementation. VA clinical studies on preventive strategies and materials in oral cancer patients have set the standards for management of such patients internationally. Finally, research, in collaboration with National Institute of Health, is ongoing to discover biological markers for the detection of oral cancer.

In summary, VA dentistry and the Office of Dentistry continue to support efforts that will benefit older veterans in the three general areas that define the mission of the Department. First, the provision to elderly veterans of quality oral healthcare, of both preventive and restorative character, is recognized by and practiced within VA as an important and cost-effective component of total health maintenance. Second, education in geriatric oral health is critical on many levels, and will continue to be a VA focus directed at veterans; VA dental staff and residents; the dental profession and dental education communities; and non-dental providers such as nurses, physicians, and family members. Third, VA dental research has enhanced and will continue to broaden our under-

standing of oral disease, its relationship to general health, and its treatment in older adults.

Geriatrics and Extended Care Strategic Healthcare Group (SHG)

Geriatrics and Extended Care has developed an extensive continuum of clinical services including specialized and primary care geriatric clinics, residential rehabilitation, community-based long-term care, nursing home care, and end of life care. The shared purposes of all geriatrics and extended care programs are to prevent or lessen the burden of disability on older, frail, chronically ill patients and their families/caregivers, and to maximize each patient's functional independence and quality of life.

The following is a description of VA's geriatrics and extended care programs and activities within each.

VA Nursing Home Care

VA nursing home care units (NHCUs), which are based at VA facilities, provide skilled nursing care and related medical services. Patients in NHCUs may require shorter or longer periods of care and rehabilitation services to attain and/or maintain optimal functioning. An interdisciplinary approach to care is utilized in order to meet the multiple physical, social, psychological and spiritual needs of patients. In Fiscal Year 2002, more than 50,304 veterans were treated in VA's 137 NHCUs. The average daily census of veterans provided care in these units was 11,974.

The system wide implementation of the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) in VA NHCUs has been completed. (RAI/MDS) is a valid and reliable standardized multidisciplinary assessment database and treatment planning process. The RAI/MDS has been in use in community nursing homes since 1990 when it was mandated by the Center for Medicare and Medicaid Services (CMS), previously the Health Care Finance Administration (HCFA), as a provision of the Omnibus Reconciliation Act of 1987.

Implementation triggers identification of problem areas that are highlighted to facilitate the development of individualized treatment plans. The interaction of the elements of the MDS also determines Resource Utilization Groups (RUGs). RUGs are used for identifying case mix and determining resource allocation to meet the needs of patients served. The RUGs can additionally serve as indicators of outcomes of care delivered. Finally, and perhaps, most importantly, the MDS will generate information regarding the quality of care patients receive. VA is providing NHCU leaders continuing education on enhancing the use of the RAI/MDS at the facility level.

Community Nursing Home Care

This is a community-based contract program for veterans who require skilled nursing care when making a transition from a hospital setting to the community. Veterans who have been hospitalized in a VA facility for treatment, primarily for a service-connected condition, may be placed at VA expense in community facilities for as long as they need nursing home care. Other veterans

may be eligible for community placement at VA expense for a period not to exceed six months. Selection of nursing homes for VA contracts requires the prior assessment of participating facilities to ensure quality services are offered. Follow-up visits are made to veterans by staff from VA facilities to monitor patient programs and quality of care. In Fiscal Year 2002, more than 13,422 veterans were treated and the average daily census of veterans in these homes was 3,866.

VA Domiciliary Care

Domiciliary care in VA facilities provides medical and other professional care for eligible veterans who are disabled by disease, injury, or age and are in need of care but do not require hospitalization or the skilled nursing services of a nursing home.

The domiciliary offers specialized interdisciplinary treatment programs that are designed to facilitate the rehabilitation of patients who suffer from head trauma, stroke, mental illness, chronic alcoholism, heart disease and a wide range of other disabling conditions. With increasing frequency, the domiciliary is viewed as the treatment setting of choice for many older veterans. Implementation of rehabilitation-oriented programs has provided a better quality of care and life for veterans who require prolonged domiciliary care and has prepared an increasing number of veterans for return to independent or semi-independent community living.

Special attention is being given to older veterans in domiciliaries with a goal of keeping them mentally and physically active and productive as well as integrated into the community. The older veterans are encouraged to utilize senior centers and other resources in the community where the domiciliary is located. Patients at several domiciliaries are involved in senior center activities as part of VA's community integration program. Other specialized programs in which older veterans are involved include Foster Grandparents, Handyman Assistance to senior citizens in the community, and Adopt-A-Vet.

In fiscal year 2002, 26,550 veterans were treated in 43 VA domiciliaries resulting in an average daily census of 5,246. Of these numbers, nearly 5,000 veterans, were admitted to the domiciliaries for specialized care for homelessness.

State Homes

The State Home Program has grown from 10 homes in 10 states in 1888, when the Federal government began providing assistance to States in care of veterans, to 114 state homes in 46 states and Puerto Rico in 2002. In 2002, a total of 26,448 state home beds are authorized by VA to provide hospital, nursing home, and domiciliary care. VA's relationship to state veterans homes is based upon two grant programs. The per diem grant program enables VA to assist the states in providing care to eligible veterans who require domiciliary, nursing home or hospital care. The other VA grant program provides up to 65 percent federal funding to states to assist in the cost of construction or acquisition of new domiciliary and nursing home care facilities, or the expansion, remodeling, or alteration of existing facilities, for domiciliary, nursing

home, and adult day care. In fiscal year 2002, the average daily census of veteran patients in state homes was 3,772 for domiciliary care, 15,909 for nursing home care, and 205 for hospital care.

Hospice and Palliative Care

VA has developed programs that provide pain management, symptom control, and other medical services to terminally ill veterans, as well as bereavement counseling and respite care to their families. The hospice/palliative concept of care is incorporated into VA facility approaches to the care of veterans at the end of life. In FY 2001, VA took the lead in an innovative training model, establishing a pilot project for six VA facilities to establish interdisciplinary fellowship training programs in palliative care.

Home-Based Primary Care (HBPC)

This program provides in-home comprehensive interdisciplinary care to veterans with complex, chronic illnesses. The family provides the necessary personal care under the coordinated support of a VA home-based interdisciplinary treatment team. The team prescribes the needed medical, nursing, social, rehabilitation, and dietetic regimens, and provides training to family members and the patient in supportive care.

Seventy-eight VA medical centers are providing HBPC services. In fiscal year 2002, the average daily census was 8,081 veterans receiving care in HBPC.

Adult Day Health Care (ADHC)

ADHC is a therapeutically-oriented, ambulatory program that provides health maintenance and rehabilitation services to veterans in a congregate setting during the daytime hours. ADHC in VA is a medical model of services, which in some circumstances may be a substitute for nursing home care. VA operated 17 ADHC centers in fiscal year 2002 with an average daily attendance of 417 patients. VA also continued a program of contracting for ADHC services in 83 medical centers. The average daily attendance in contract programs was 932 in fiscal year 2002.

Community Residential Care

The Community Residential Care program provides residential care, including room, board, personal care, and general health care supervision to veterans who do not require hospital care but who, because of health conditions, are not able to resume independent living and have no suitable support system (e.g., family or friends) to provide the needed care. All homes are inspected by a multidisciplinary team prior to incorporation of the home into the VA program and annually thereafter. Care is provided in private homes that have been selected by VA, and is at the veteran's own expense. Veterans receive case management visits at least monthly from VA health care professionals. In fiscal year 2002, approximately 10,000 veterans were cared for in this program, utilizing nearly 2,000 homes.

Homemaker/Home Health Aide (H/HHA)

VA provided H/HHA services for veterans needing nursing home care. These services are offered in the community by public and private agencies under a system of case management provided directly by VA staff. One hundred and eighteen VAMCs purchased H/HHA services in fiscal year 2002 with an average daily census of 4,180.

Geriatric Evaluation and Management (GEM) and Geriatric Primary Care

The (GEM) Program includes inpatient units, outpatient clinics, and consultation services. A GEM unit is usually a functionally different group of beds (ranging typically in number from 10 to 25 beds) on a medical service, an intermediate care unit of the hospital, or nursing home care unit, where an interdisciplinary health care team performs comprehensive, multidimensional evaluations on a targeted group of elderly patients who will most likely benefit from these services. The GEM unit serves to improve the diagnosis, treatment, rehabilitation, and discharge planning of older patients who have functional impairments, multiple acute and chronic diseases, and/or psychosocial problems. GEM clinics provide similar comprehensive care for geriatric patients not in need of hospitalization as well as follow-up care for older patients to prevent their unnecessary institutionalization. GEM programs and Geriatric Primary Care clinics also provides geriatric training and research opportunities for physicians and other health care professionals in VA facilities. In 2002, there were 57 inpatient GEM Programs and more than 189,726 visits to GEM and Geriatric Primary Care Clinics.

Respite Care

Respite care is a program designed to provide the spouse or other caregiver temporary relief from the burdens of caring for a chronically disabled veteran at home. Public Law 106–117 expanded the provision of respite services from VA hospitals or VA nursing homes to community nursing homes and non-institutional settings including but not limited to services in-home. The long-range benefit of this program is that it supports the veteran's desire to delay or prevent nursing home placement. All VA facilities offer respite care. Respite care may be provided to eligible veterans for up to 30 days in a calendar year. The 30-day program limit includes the sum of respite specific resources and services received in the home, community nursing home, or other community-based or institutional settings in or outside the VA. A professional or team of professionals responsible for program management coordinates respite services.

Alzheimer's Disease and Other Dementias

VA's program for veterans with Alzheimer's disease and other dementias is decentralized throughout the medical care system, with coordination and direction provided by the Geriatrics and Extended

Care SHG in VA Central Office. Veterans with these diagnoses participate in all aspects of the health care system.

In fiscal year 2002, VA investigators were involved in 367 funded research projects on Alzheimer's disease and other dementias. Funding was provided by VA as well as non-VA sources.

In fiscal year 2002, VA provided a national training program called Advances in Home-Based Primary Care for End of Life in Advancing Dementia II (AHEAD II) to 20 competitively selected clinical teams from VA home and outpatient primary care settings in 13 Veterans Integrated Service Networks (VISNs). This six-month initiative included two in-person learning sessions plus ongoing collaboration through regular conference calls, a listserve and web site. The teams learned a rapid-cycle quality improvement process as well as information on dementia identification and diagnosis, symptom management, caregiver support, and staff education. This project built upon the AHEAD I training program, which began in fiscal year 2001 with 20 VA Home-Based Primary Care teams.

Also in fiscal year 2002, VA Upstate New York Healthcare Network (VISN 2) continued its data collection for "Chronic Care Networks for Alzheimer's Disease" (CCN/AD), a national demonstration project co-sponsored by the Alzheimer's Association and the National Chronic Care Consortium.

In addition, the VA Central Office Geriatrics and Extended Care Strategic Healthcare Group and VA Medical Inspector's Office continued their Dementia Safety quality improvement project focused on issues of driving and gun safety in veterans with dementia. In fiscal year 2002, they pilot-tested a questionnaire and educational pamphlets for use in VA outpatient settings.

Geriatric Research, Education, and Clinical Centers (GRECCs)

GRECCs are designed to enhance VA's capability to develop state-of-the-art care for the elderly through research, training and education, and evaluation of alternative models of geriatric care. First established by VA in 1975, the GRECCs continue to serve an important role in further developing the capability of the VA healthcare system to provide cost-effective and appropriate care to older veterans. In fiscal year 2002, there were 21 GRECCs in the VA system.

In fiscal year 2002, GRECCs continued to make a number of contributions to the field of aging and care of the elderly. Some examples of these contributions are: coordination by the Durham GRECC of a randomized, controlled, multi-site trial of Geriatric Evaluation and Management (GEM) units and clinics, the results of which were published in the *New England Journal of Medicine*; a patent received by the Madison CRECC for standardized, radiopauge fluids that are used in video-fluoroscopic evaluations of swallowing disorders; and mapping and cloning of a major melanoma skin cancer risk gene by the Salt Lake city GRECC. During fiscal year 2002, the VA Geriatrics and Gerontology Advisory Committee made site visits to Cleveland and to Pittsburgh, to evaluate the GRECCs that are hosted there. These site visits were made in accordance with 38 U.S.C. Sections 7314 and 7315, requiring an evaluation within 3 years of the date of establishment of a new

GRECC. As a result, the Cleveland GRECC and the Pittsburgh GRECC were fully approved for continued funding.

Mental Health Strategic Healthcare Group (SHG)

It is anticipated that the number of people older than 65 years with psychiatric disorders in the United States will increase from about four million in 1970 to 15 million in 2030. In the year 2000 veterans age 65 or older numbered 9.6 million and are estimated to remain in the range of 8.7 to 9 million until the year 2020. Most of these will be veterans of WW II and the Korean conflict until approximately 2010, when aging Vietnam era and Gulf War veterans begin to augment that age group. By 2015, the latter two cohorts will account for the great majority of elderly veterans. Between 1999 and 2010 the number of veterans age 75 and over will remain stable between 3.8 and 4.5 million. Although the reported prevalence of mental illness among the elderly varies, conservative estimates for those age 65 years or older include a minimum of 10 percent with dementia of any type, and an additional 15 to 30 percent with other psychiatric disorders. If a 30 percent estimated rate is used, it can be expected that over the next 20 years from 2.3 to 2.7 million veterans will need psychogeriatric care.[1] Psychogeriatric services in VHA are integrated into a full service health care system that includes mental health and substance abuse treatment within the broader medical, surgical, and primary care environment and provides a continuum of care from hospital to home care settings. In FY 2002, while 48 percent (2.1 million) of VA outpatients seen anywhere in VHA were 65 years or over and 26% (53,461) of VA patients with a diagnosis of psychosis were over the age of 65,[2] only nine percent (188,708) of all VA outpatients were seen in specialty mental health clinics.[3] Thus the majority of care for mental disorders in elder veterans is presumably performed in primary care or medical surgical settings. VHA has continued to press for integration of mental health and primary care for older veterans in facility clinics as well as in the growing numbers of community-based outpatients clinics. The MHSHG is working closely with the Geriatrics and Extended Care and Acute Care Strategic Healthcare Groups at the national level to insure that planning for elder veterans with mental health and physical problems is coordinated at all levels of our organization.

UPBEAT (Unified Psychogeriatric Biopsychosocial Evaluation and Treatment)

This six-year clinical demonstration project at nine VA facilities screened elderly patients in acute medical and surgical VA settings for undiagnosed symptoms of depression, anxiety, and substance use disorders. Of 1,687 patients screened, 48 percent screened positive for symptoms of anxiety and depression and 26 percent for depression alone, despite an absence of past or recent psychiatry history. From a randomized half-sample of 839 of those veterans, 58.6

[1] Sadock and Sadock. *Comprehensive Textbook of Psychiatry* 7th Ed. Lippincott, Williams & Williams, 2002, p. 3141.
[2] SMITREC, Care for Veterans with Psychosis in the VHA, FY 02, Table 1A.
[3] SMITREC <opage02.xls>

percent received a formal mental health diagnosis within an average of three months post-discharge. Of these,

21.8 percent were diagnosed with an adjustment disorder,

15.4 percent for anxiety,

7.4 percent a mood disorder including depression, and

14 percent for other disorders.

The high occurrence of an adjustment disorder was not anticipated.

Aging, Mental Health, Substance Abuse, and Primary Care Project

This Primary Care Research in Substance Abuse and Mental Health for Elderly (PRISMe) study was funded jointly by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Veterans Affairs (VA), and the Health Resources and Services Administration (HRSA). It is randomized, multisite investigation comparing the effectiveness of either behavioral health systems that were integrated into primary care clinics or enhanced referral systems where patients were referred to specialty mental health clinics away from the primary care setting. Six study sites funded by SAMHSA and five study sites funded by the VA were selected that had, or had plans to develop both integrated and referral models in their primary care clinics. Clinical and cost outcomes were obtained at three, six and 12 months post enrollment. The PRISMe study has enrolled 1,610 patients with depression or anxiety and 634 with at-risk drinking conditions. Preliminary results suggest that a higher percent of patients were engaged in treatment who were randomized to the integrated sites, however the six-month and one-year treatment outcomes are not yet available. When completed, this study should guide VA policy with regard to effective ways to integrate mental health care into primary care sites nationwide.

Rahabilitation Strategic Healthcare Group (SHG)

The Rehabilitation SHG has four separate and distinct services, Physical Medicine and Rehabilitation, Audiology and Speech Pathology, Blind Rehabilitation and Recreation and Creative Art Therapies.

Physical Medicine and Rehabilitation

Physical Medicine and Rehabilitation services strive to provide all referred older veterans with comprehensive assessment, treatment and follow-up care for psychosocial and/or physical disability affecting functional independence and quality of life. The older veteran's abilities in the areas of self-care, mobility, endurance, cognition and safety are evaluated. Therapists utilize physical agents, therapeutic modalities, exercise, and adaptive equipment and provide treatment to enhance function in activities of daily living and vocational/avocational activities that facilitate the veteran's ability to remain in the most independent life setting. Rehabilitation personnel provide education to the veteran and family members about adjustment to a disability or physical and social limitations and instruct them in techniques to maintain independence despite disability.

There are approximately 45 Comprehensive Integrated Inpatient Rehabilitation Programs, (CIIRPs) within VHA. Approximately half of the programs reside within long term care settings. Physicians with extensive rehabilitation experience, usually board certified physiatrists, lead interdisciplinary teams of professionals to focus on outcomes of functional restoration, clinical stabilization, or avoidance of acute hospitalization and medical complications.

A uniform assessment tool, the Functional Independence Measure (FIM), is used throughout the VA rehabilitation system. Patients are evaluated on 18 elements of function at the time of admission, regularly during treatment, and at discharge. Application of FIM results to quality management activities assist local and national rehabilitation clinicians and managers to maximize effective and efficient rehabilitation care delivery. An administrative database called the Uniform Data System for Medical Rehabilitation (UDS/mr) monitors outcomes of care and increases the accuracy of developing predictors and ideal methods of treatment for the older veteran with various diagnoses. Through a national contract with UDS/mr, facilities with rehabilitation programs provide data and receive outcome reports as part of a national and international UDS/mr data bank. Use of the FIM as a functional assessment tool is available to all VA facilities through connectivity to the Functional Status and Outcomes Database (FSOD) for Rehabilitation housed at the VA Austin Automation Center, Austin, TX. The FSOD allows tracking of rehabilitation outcomes across the full continuum of care based upon a severity of illness index which classifies each patient into a specific Functional Related Group (FRG) based on his/her impairment. Rehabilitation therapists lead and participate in innovative treatment, clinical education, staff development and research. Rehabilitation professionals work within VA HBPC Programs, Independent Living Centers, GEM Units, ADHC Centers, Day Treatment Centers, Domiciliaries, NHCUs, GRECCs and Hospice Care Programs. Applying principles of health education and fitness, rehabilitation staff develops and provides programs aimed at promoting health and wellness for the aging veteran.

Driver rehabilitation centers are staffed at 40 VAMCs to meet the needs of aging and disabled veterans. With the growing numbers of older drivers, VA emphasizes the training of the mature driver. Classroom education, updates on laws, and defensive driving techniques are supported with behind-the-wheel evaluations by trained specialists.

Audiology and Speech Pathology

In addition to traditional rehabilitation disciplines, the Rehabilitation Strategic Healthcare Group also includes Audiology and Speech Pathology. Audiology is primarily concerned with the identification and management of veterans with hearing and balance disorders. Most veterans with hearing loss receive hearing aids and other assistive devices. In FY2002, VA issued over 254,000 hearing aids. For veterans with more severe hearing loss, VA provided cochlear implants at ten designated cochlear implant centers. Speech Pathology is primarily concerned with identifying, treating, and managing veterans with speech, language, voice, and swal-

lowing disorders. These disorders are frequently associated with disease in the elderly including stroke, degenerative neurological disease, and head/neck cancer. Speech-language pathologists play a key role in the early identification, treatment, and management of swallowing disorders that can lead to serious medical complications if left untreated. Speech-language pathologists work collaboratively with ENT, GI Medicine, Neurology, Geriatrics, Primary Care, Nutrition and Food Service, and Nursing. Speech-language pathologists are also primarily involved in restoring voice function to veterans who have lost the ability to speak due to stroke, degenerative neurological disease, or cancer. VA and Department of Defense (DoD) worked collaboratively to develop joint clinical practice guidelines for the management of stroke. Speech-language pathologists supplement FIM-based functional assessments using the National Outcomes Measurement System (NOMS), a collaborative venture between VA and the American Speech-Language-Hearing Association. NOMS allows speech-language pathologists to track clinical outcomes on specific disorders related to speech, language, and swallowing deficits. The NOMS data are available to all VA facilities through the Functional Status and Outcomes Database (FSOD) for Rehabilitation housed at the VA Austin Automation Center, Austin, TX.

BLIND REHABILITATION

The program is designed to improve the quality of life for blinded and severely visually impaired veterans through the development of skills and capabilities needed for personal independence, emotional stability, successful integration into the community and family environment. It is comprised of 10 Inpatient Blind Rehabilitation Centers, 92 Visual Impairment Services Team Coordinators, 20 Blind Rehabilitation Outpatient Specialists, 5 National Program Consultants, and Inpatient Computer Access Training programs at medical centers throughout the country and Puerto Rico. Services are provided using a multi-disciplinary team approach.

RECREATION/CREATIVE ARTS THERAPIES

Recreation/creative arts therapists working in VA's long-term care programs provide interventions and therapeutic programs to enhance attention, memory, perception and problem-solving skills, improved social interactions skills, reduction of inappropriate behavior, and increases in perceived quality of life. Therapists treatment data is included in the Resident Assessment Instrument-Minimum Data Set (RAI–MDS). The instrument is a uniform set of items and definitions for assessing all resident in nursing facilities. Recreation Therapy in conjunction with VHA's Employee Education System sponsors a Distance Learning Program for recreation/creative arts therapists with up-to-date training on professional practice trends. In, 2002 Recreation Therapy National Program Office and the Department of Health and Human Services co-sponsored training for professionals, family, and volunteer caregivers at the National Veterans Golden Age Games.

Pharmacy Benefits Management Strategic Healthcare Group (SHG)

The Under Secretary for Health established the Pharmacy Benefits Management (PBM) Service line in 1996 to provide a focus within the VHA concerning the appropriate use of pharmaceuticals in the health care of veterans. A secondary goal was to decrease the overall cost of health care through achievement of the PBM's primary goal. As VHA has transitioned from an emphasis on inpatient care to ambulatory/primary care, pharmaceutical utilization has increased dramatically and will continue to do so.

One of the key organizational elements of VHA's PBM is its group of field-based physicians called the Medical Advisory Panel (MAP). The MAP provides leadership and guidance to the PBM in addressing the five functions of the PBM. These functions are: (1) management of pharmaceutical costs; (2) management of drug utilization; (3) management of drug distribution systems; (4) promotion of best practices; and (5) education of clinical caregivers and patients.

The PBM serves a qualitative and quantitative role in addressing the medication needs of older veterans. In a patient population that frequently has co-morbidities and multiple drug therapies, the actions of physicians, nurses and pharmacists to improve the drug use process are essential in realizing the goal of the appropriate use of pharmaceuticals. To date, twelve Pharmacologic Management Guidelines, twenty Drug Class Reviews, three Clinical Practice Guidelines, forty Criteria for Use documents, twenty-five Drug Monographs, four Pocket Cards, three News Alerts, and three Therapeutic Interchange documents have been developed and promulgated for use in the VA healthcare system. Many areas of interest and merit in addressing the health conditions of elderly patients are included in the published drug treatment guidelines; they include Depression, Chronic Heart Failure, Benign Prostatic Hyperplasia, Hyperlipidemia, Hypertension, COPD, Type 2 Diabetes, Alzheimer's Disease, Erectile Dysfunction, GERD, and Criteria for Use for COX–2 Inhibitors.

During FY 2002, increases in the utilization of pharmaceuticals and the dollars expended on pharmaceuticals continued to occur across VHA. Through the use of effective contracting strategies tied to the development of disease management guidelines, VHA provides quality medical care at an affordable price. Specifically, the average cost of a 30-day equivalent outpatient prescription remained essentially flat from FY 1999 through FY 2002.

Allied Clinical Services Strategic Healthcare Group (SHG)

NUTRITION AND FOOD SERVICE

Research indicates that older Americans are the population most likely to have chronic and acute nutrition-related health problems. VA dietitians have developed initiatives that address such health problems of the elderly, hospitalized veteran patients who may be at high nutritional risk. An Interdisciplinary Task Group has developed a Nutrition Performance Monitor (NPM) that identifies nutrition indicators/monitors for patient at risk for malnutrition. These nutrition indicators are an integral part of the VA electronic database and provide a screening tool for professional dietitians to

respond promptly with nutrition assessment and intervention to such patients. These nutrition performance monitors provide a nutrition profile of acute care, chronic and elderly long-term care patients. This nutrition profile will be able to assist dietitians to make decisions about the level of care required to adequately accommodate elderly veterans' nutritional needs.

VA dietitians provide meals to many community Meals-on-Wheels programs and State Veterans Home through local contracts and sharing agreements. Also, more than 35 State Veterans Homes purchase their menu food items from the VA Subsistence Prime Vendor Contract. Dietitians continue to develop the pureed food products to enhance the appearance, taste, quality, palatability, and acceptability of food for geriatric patients with dysphagia.

SOCIAL WORK SERVICE

Social Workers are an active, integral part of the interdisciplinary health care team in every program serving elderly veterans across the continuum of care. The full range of psychosocial treatment is available to veterans and families considering long term care to help them assess their needs, identify resources, select alternatives and coordinate referrals between VA and community programs. Each veterans subject to Long-Term Care Copayments will receive social work help in the application process and in finding and choosing appropriate health care options. Older veterans with changing physical conditions and circumstances may need assistance in adjusting to losses and limitations. Family caregivers also need support and help with the added responsibilities and changes they face.

Key functions provided by social workers in long-term care include: Psychosocial Assessment; Treatment Planning; Discharge Planning; Community Liaison and Referral; Case Management; Crisis Intervention; Psychosocial Treatment; Mental Health Services; Family Liaison; Patient Advocacy; Patient and Family Education; End of Life Planning and Documentation. Social workers have knowledge and skills in community and family systems that prepare them to participate on management teams for long term care programs, developing, directing, coordinating, monitoring and improving services.

CHAPLAIN SERVICE

Supporting the spirituality of aging veterans is essential to their wellness and wholeness. Their spirituality helps them respond to the potential fullness of life despite the problems that arise from illness and longevity. Failure to address the spiritual well being of aging veterans neglects an essential component of their lives and has strong consequences affecting their quality of life.

It is crucial to gain an understanding of the spiritual journeys of aging veterans and these include the spiritual injuries incurred along the journey. With appropriate spiritual assessments, follow-up pastoral care focuses on the veterans and family members in helping them to use their religious/spiritual resources to cope with matters of life review, meaning, and adjustment to loss.

The challenge for aging veterans is to make sense of life at a stage when changes and losses occur with bewildering and, some-

times, overwhelming frequency and intensity. If a veteran sees aging as more loss than gain, then what is the value and meaning of added years? The sense of loss prompts the questions, "Has it been worth it? Has my life meant anything? Does it mean anything now? Many aging veterans use their religious/spiritual beliefs to help them answer these questions. In an age and culture that emphasizes beauty, mobility, wealth, and power, all of which may be lost through the aging process, veterans need an effective means of coping with frailty, suffering, loss, loneliness, or dementia.

As personal health begins to fail and dependency becomes more apparent, there is an increasing awareness of approaching death. Pastoral care can help aging veterans understand and accept death as a part of a larger picture that is meaningful and sacred. Research supports the importance of spirituality to well being and validates the efforts of those long term care facilities that provide a framework of care for services that include the spiritual dimension as an integral component of that care. As the chaplain provides care for the elderly in their search for meaning, several significant themes seem to emerge:

First, the ability to face reality is strengthened and the likelihood of giving in to the limitations of aging are greatly diminished;

Second, as the elderly search for meaning in their own personal values, the growth and self-exploration/acceptance that are embraced in the search enables them to experience themselves as fuller, richer persons;

Third, through the sharing of stories elderly are able to reframe their life events in order to experience meaning and purpose rather than despair.

Fourth, they experience a rite of passage that provides the opportunity to bring closure, and this includes both the passing on and receiving of a blessing.

Diagnostic Services Strategic Healthcare Group (SHG)

The clinical services of Pathology and Laboratory Medicine, Radiology, and Nuclear Medicine constitute the Diagnostic Services Group. Each of these clinical services provides direct services to veteran patients and to clinician-led teams in ambulatory/primary care, acute care, mental health, geriatrics and long-term care, and rehabilitation medicine.

Diagnostic Services staff are educated on special care of elderly. Pathology and Laboratory staff, for example, receive special training on phlebotomy with the elderly. In addition, normal values of various laboratory tests may be different in the elderly. These differences are incorporated into each VA facility's reference on normal ranges for tests.

Prosthetic and Sensory Aids Strategic Healthcare Group (SHG)

The mission of the Prosthetic and Sensory Aids Service (PSAS) is to provide specialized, quality patient care by furnishing appropriate prosthetic equipment, sensory aids and devices in the most economical and timely manner in accordance with authorizing laws, regulations and policies. PSAS serves as the pharmacy for assistive aids and PSAS prosthetic representatives serve as case

managers for the prosthetic equipment needs of the disabled veteran.

Currently, the majority of geriatric veteran patients treated in VHA's primary care clinics receive some type of prosthetic appliance. PSAS furnishes such appliances as eyeglasses, canes, crutches, wheelchairs, hearing aids, orthopedic shoes, arch supports, artificial limbs, and home oxygen equipment. PSAS also arranges for training and instructions on the use of these prosthetic appliances.

PSAS employees simplify the geriatric patients' communication difficulties with private home care durable medical equipment companies. They arrange for delivery and training on a variety of devices such as hospital beds, patient lifts, and environmental control appliances that the geriatric patient would have considerable difficulty in arranging themselves. Vendors must have in-depth prescription and unique needs of the patients explained to them by PSAS employees prior to delivery, installation and instructions.

PSAS employees are also a vital link between the local VA clinic teams and geriatric veteran patients in developing the prescription needs of patients with catastrophic disabilities. Knowledge about appliances and available components in the private sector and in VA is used to complete the prosthetic appliance prescription in a manner that meets a veteran's needs as well as maximizes the VA resources.

Telemedicine Strategic Healthcare Group (SHG)

The mission of the Telemedicine SHG is to further the innovative use of information and communications technologies to provide and support health care for veterans across distance and time barriers. VHA continues to play a leadership role in telemedicine that involves the use of different communication technologies to transmit diagnostic and therapeutic information to provide health care services to remote locations. Telemedicine plays an increasingly important role in improving health care for veterans and has been demonstrated to provide greater access to care, improve the continuity and timeliness of care, reduce travel costs. Clinicians in many clinical specialties are using telemedicine to improve the continuity of care for veterans at home, in ambulatory care clinics, and in hospitals. The Telemedicine SHG continues to evaluate the effectivenss of telemedicine and work with the VISN's and VA facilities to introduce new clinical processes based on information technologies to assist clinicians in meeting the health care needs of older veterans and reduce the barriers of distance and time that can sometimes restrict the availability of care.

Spinal Cord Injury/Disorders Strategic Healthcare Group (SHG)

The Spinal Cord Injury and Disorders (SCI&D) SHG provides primary, specialty, and rehabilitation care for veterans with spinal cord injuries and disorders. Due to health care interventions and improved methods of disability management, life expectancies for persons with SCI continue to increase, but are still somewhat below life expectancies for those with no spinal cord injury. The average age of veterans with SCI has been estimated to be 12 years older than the average age in the general SCI population. Over 20 percent of the general SCI population is over the age of 61, and

since the veteran geriatric population is proportionately larger than the general population, this percentage is also significantly larger. A recent program review, noted that 32 percent of veterans offered initial rehabilitation in VA for new SCI onset are over the age of 65 while only ten percent are over the age of 65 in other models of SCI&D care. There have been increases in the incidence of aging-related spinal cord problems and increasing survival rates for older persons with SCI in addition to basic demographic changes. Major clinical issues related to aging with a spinal cord injury being addressed in VHA include recurrent pressure ulcers, degenerative processes related to overuse syndromes, long-term urinary tract and gastrointestinal tract complications, cardiovascular changes and silent ischemia, pulmonary complications, home care services, and the psychological and social impact of losing caregiver support. The older person with SCI is at increased risk for developing these secondary conditions as well as other diseases. Performance measures are used to help assess the treatment of veterans with SCI and discharge to non-institutional, community living is tracked. Greater than 95 percent of discharges from the SCI Centers were to non-institutional settings in FY 02.

VA is committed to planning for the extended care needs of this population through the CARES initiative and designation of extended care beds for priority use by veterans with spinal cord injury. Options in addition to extended care beds include respite care within the SCI Centers and bowel and bladder care through Fee Basis home health services.

Research on aging and SCI&D is a high priority in VA. The SCI Quality Enhancement Research Initiative summarized important scientific and clinical knowledge gaps related to unique issues of aging with an SCI injury through consumer and provider focus groups.

Forensic Medicine Strategic Healthcare Group (SHG)

The mission of the Forensic Medicine SHG is to act as a resource for the Under Secretary for Health and provide consultation and leadership in several areas in which legal and medical issues converge. The work of this SHG directly affects the quality and safety of medical care provided to veterans.

Specifically, but not by way of exclusion, the Forensic Medicine SHG:

- Reviews all Veterans Health Administration (VHA) medical facility requests for exchange visitor (J–1 visa) physician waivers under the Immigration and Nationality Act.
- Oversees the malpractice payment review activities of the VHA Office of Medical/Legal Affairs.
- Reviews VHA contracts for adherence to current laws, regulations and guidelines.
- Advises Veterans Benefits Administration (VBA) on VHA issues related to claims processing activities.

B. Office of Nursing Services

Office of Nursing Services in support of VHA's Vision 20/20, continues to rank care of the elderly veteran as a major priority. Nurses at every level of the organization are committed to leader-

ship in the clinical, administrative, research, and educational components of gerontological nursing. Powerful societal forces in both the Federal Government and the private sector require even greater collaboration and teamwork as nursing strives to integrate advances in technology and information management. Nursing participates in the transition from inpatient to outpatient healthcare within the managed care model.

Nurses continue to provide patient care expertise in preventative care and health promotion initiatives, to preserve both the veterans' and their significant others' independence. Team approaches to improving the health status of aging veterans have fostered optimum levels of self-care, improved productivity, and enhanced quality of life. Health screening, education, primary care and referral of elderly veterans are critical functions necessary to manage health care needs and place the veteran in the most appropriate level of care. Level of care may range from enhanced HBPC, including Home Tele-Health as the least restrictive setting to inpatient nursing home care in the most restrictive environment. Nurses have facilitated interdisciplinary leadership to create and strengthen programs to help keep patients in their homes as long as possible. Program expansions include ADHC, HBPC, Care Coordination and home Tele-Health Program. Nurses in wellness clinics provide supervision, screening and health educational programs to assist veterans and their significant others in fostering and maintaining healthy lifestyles.

Effective utilization of advanced practice nurses (APN) in the provision of health care services is a critical component of VHA's mission to provide cost effective quality primary care across a continuum of care. This continuum of care for aging veterans includes primary care, acute care, long-term care, palliative care, respite, and community agencies. Gerontological advanced practice nurses provide primary care and continuity of care as the V.A. expands the care coordination of veterans. Nursing Palliative Care is a systematic and rational approach to caring for the most complex patients in the hospital setting. Through sustained patient partnerships, APNs provide health care for aging patients in diverse settings, minimizing illness and disabilities and focusing on health promotion, disease prevention and health maintenance.

Primary care is provided to aging veterans by either a physician or a nurse practitioner, often in collaboration with a care team, including psychiatry, psychology, social work, dietitian, chaplain, rehabilitation therapy, pharmacy and others. Primary care services are based on the long-term care needs of aging patients including those with multiple and chronic medical problems, functional disabilities, cognitive impairments and weakened social support systems. Services are provided across the continuum from health promotion and disease prevention to screening for community services including hospice care evaluation.

Nurses facilitate the restoration of functional abilities of veterans with chronic illnesses and disabilities. Programs for the physically disabled and cognitively impaired are administered by nurses and advanced practice nurses in settings representing ambulatory care, inpatient care and home care. These patient centered treatment programs and rehabilitation teams are goal-directed with physical

and psychosocial reconditioning or retraining of patients. Patient and family teaching are a major component of each program.

Family/significant others have a key role in providing support to veterans. Both are assisted in learning and in maintaining appropriate patient/caregiver rights and responsibilities. VA nurses contribute to planning, implementing and evaluating services for veterans in the community-at-large.

Committed to leadership in education, VA nurses provide creative learning experiences for both undergraduate and graduate nursing students. Nursing education initiatives including "distance learning" are being developed to provide skills and competencies necessary to function in primary and managed care settings. Students are able to work and study with VA nurses who have clinical and administrative expertise in aging and long-term care. These include nurses in various organizational and leadership roles. Nurses have responded to the growing emphasis upon end-of-life issues by providing training and local programs for palliative care, including hospice programs.

To assist facilities in meeting performance measures, nurses have been involved in developing creative alternatives to acute inpatient care. This includes chronic ventilator programs, which extend into nursing home and even home settings. There is also increased emphasis upon defining VA NHCU programs as transitional and rehabilitative services providing a realistic discharge option for patients continuing to require nursing intervention. VA NHCU's continue to demonstrate a significant restraint reduction. Decreased restraint usage is attributed to interdisciplinary reassessment of the patient's treatment. Each patient/resident has a comprehensive interdisciplinary plan of care, which facilitates reduced restraint usage. Resident outcomes include a decrease in the number of falls and injuries with an increase in resident's alertness, happiness, muscle strength, independence and pride. Nurses and other members of the interdisciplinary team are proud of these clinical outcomes and VA NHCU's success in reducing the use of chemical and physical restraints in care of the elderly. Such an environment enhances resident behaviors in independence, decision-making and socialization.

Multi-arts programs have been developed including Tai Chi, Dance, Art Appreciation, Hands-on Art, Sign Language, and Creative Writing. Patient outcomes include an increase in mobility, functions, and an increase in spontaneity and happiness as measured by standardized instruments.

Committed to research, VA nurses continue to change and reshape clinical nursing practices. Nursing research is improving care delivery and health promotion in the following areas:

- Alternative to Institutional Care
- Wound Care and Effectiveness of Treatment Regimens
- Risk Assessment for Falls
- Restraint Minimalization and Alternatives to Restraints
- Interdisciplinary/Assessment Tool Effectiveness
- Patient Education, Health Promotion and Maintenance
- National Minimum Data Set Implementation
- Pain Assessment in Cognitive Impaired

• Assessment of Pain/Implementation of Pain as the 5th Vital Sign

Timely application of research findings to clinical care in all practice settings will improve the quality of care and quality of life to aging veterans. Quality of life is an essential component for evaluating the effects of nursing care in both research and clinical practice. Research by nursing as a discipline and in collaboration with other members of the healthcare team continues to focus on specific patient care outcomes including quality of life, assessment of pain, effectiveness of care interventions, cost effectiveness, and patient satisfaction.

C. Office of Research and Development

VA's Medical and Prosthetic budget funds a vigorous research effort that investigates aging and its affects from a number of directions that reflect the multi-faceted nature of that condition.

The Office of Research and Developments' commitment to research on aging veterans resulted in its establishment as one of 17 Designated Research Areas (DRA) under which virtually all VA research and development programs and projects fall. Moreover, aging receives the highest funding of any DRA. For clarity, a DRA is defined as an area of research in which VA has a particularly strong strategic interest because of the prevalence of conditions within the VA patient population, the uniqueness of a specific patient population and its disease burden to the VA system or the importance of the question to health care delivery within VA. Clearly, veteran aging and its associated problems fall within this definition. VA research that is considered to fall primarily within the Aging DRA includes:

• Normal age-related changes in the body's structure and function.

• Aging syndromes, such as frailty, immobility, falls, cognitive impairment.

• Compound problems and co-morbidities, such as dementia and hip fractures.

• Care of elderly veterans.

• End-of-life issues—hospice care, "quality of dying", and similar areas.

Below are highlights of recent advances in research on aging veterans from each of the Office of Research and Development's programs: Medical Research, Rehabilitation Research and Development, Health Services Research and Development, and the Cooperative Studies Program.

Cooperative Studies Program

The Cooperative Studies Program (CSP) is a component of the Office of Research and Development and supports multi-center clinical studies where multiple VA medical centers (and potentially non-VA center) study collectively a selected medical problem. CSP consists of four Coordinating Centers (CSPCCs), a Clinical Research Pharmacy, and three Epidemiological Research and Information Centers (ERICs). CSP exists to provide credible, consistent, and effective answers to major scientific questions that determine evidence-based medical practice in VA and in the country.

A. Aging-related Studies

DEEP BRAIN STIMULATION FOR PARKINSON'S DISEASE

This landmark VA clinical trial is comparing two promising surgical treatments for Parkinson's disease among patients who are no longer responsive to the best medical therapy. The trial will assess the effectiveness of surgically planted electrodes that provide stimulation to two regions of the brain (the subthalamic nucleus and globus pallidus) that have shown promise in mediating the physical tremor associated with Parkinson's Disease, and compare each to usual medical therapy. Prior to initiation of the trial, the NIH, National Institutes for Neurological Disorders and Stroke approached the VA and the VA agreed to partner with the NIH in the collaborative conduct of the trial.

GLYCEMIC CONTROL IN TYPE II DIABETES

A quarter of the patients treated in VA have type II diabetes. The treatment costs for diabetes care and management is extremely high. The VA has initiated the largest US clinical trial among type II diabetics (1700 patients) to determine whether glycemic control, achieved through intensification of pharmaceutical treatment, is effective in preventing major organ complications among patients no longer responsible to oral agents alone.

SHINGLES VACCINE TRIAL

Shingles in older people is extremely painful and disabling. There exists no effective treatment for people who suffer from shingles nor an effective method to prevent the condition. This study will test a promising new vaccine to prevent shingles and reduce its severity and complications. The randomized, controlled trial will enroll 35,000 older veterans for a minimum of three years. If the vaccine proves successful, it will supply a safe and cost-effective means for reducing the severe impact of shingles and its complications on the health of older veterans.

PROSTATE CANCER

Prostate cancer is the most common cancer among men and second leading cause of death in men. CSP is conducting three programs that seek to learn more about this disease.

The Prostate Cancer Intervention Versus Observation Trial (PIVOT) is a 15-year, randomized study involving 2,000 men. VA, in collaboration with the National Cancer Institute (NCI) and the Agency for Health Care Policy and Research (AHCPR), is addressing questions remain concerning long-terms outcomes for prostate cancer treatment through a landmark study that compares the two most widely used treatment methods: radical prostatectomy, in which the prostate is surgically removed, and expectant management or "watchful waiting," in which only the disease symptoms are treated.

VA has entered collaborations with the NCI and the Southwest Oncology Group to study the effects of Vitamin E and Selenium in the primary prevention of prostate cancer. The proposed Selenium Vitamin E Cancer Prevention Trial (SELECT) is a randomized,

double-blind, placebo controlled, factorial design trial among 30,000 healthy men without prostate cancer.

Another study on prostate cancer will look at the racial differences in the incidence and mortality of the disease. Among African Americans, the incidence and mortality from prostate cancer is highest. This research will provide insight into genetic-environmental interactions that initiate and promote prostatic neoplasia, as well as address whether there are differences in patterns of care that impact morbidity and survival.

COLORECTAL CANCER

The relative five-year survival for colorectal cancer is approximately 40 percent among veterans, substantially lower than the general population of 61.7 percent (colon) and 59.3 percent (rectum). Colorectal cancer is preventable through screening, and, if diagnosed in an early stage, is curable.

This is the first study to examine factors that may explain the worse prognosis for veterans with colorectal cancer. If modifiable factors such as physician and patient delay in diagnosis, or poverty explain the increased mortality among veterans, educational programs and interventions that improve the process of care associated with screening and diagnosis can be instituted.

HEALTH SERVICES RESEARCH AND DEVELOPMENT SERVICE

Research supported by the Health Services Research and Development Service (HSR&D) is designed to enhance veterans' health and functional status and the quality of care provided to elderly veterans. Elderly veterans and their special health care needs have always been a major focus of HSR&D activity. HSR&D researchers focus on identifying effective strategies for the organization and delivery of health services and for optimizing patient- and system-level outcomes. They employ the expertise and perspectives of clinicians, social scientists, and managers to advance the field of health services research and answer practical questions that are important both inside and outside VA.

Various funding mechanisms are used to promote health services research in aging. These include investigator-initiated research, service (HSR&D) initiated research, and the VA management consultation. In addition, HSR&D in collaboration with the Nursing Strategic Healthcare Group, encourages research on nursing topics. Several of the nursing projects are directly related to aging, especially long-term care. All proposals funded by HSR&D undergo rigorous peer review to assure scientific/technical merit and important to VA. Funded projects range in duration from one to five years.

Supporting HSR&D's researchers is an infrasture of 13 Centers of Excellence (CoEs), 8 Quality Enhancement Research Initiative Groups (QUERI), 9 Research Enhancement Award Programs (REAPs), 6 Targeted Research Enhancement Programs (TREPs), and 4 Resource Centers. Many of these programs and centers specifically focus on aging-related topics.

A. Aging-related Studies

Through its various programs, HSR&D supports research that is either pertinent to aging veterans or addresses aspects unique to aging. In the first case, a large proportion of HSR&D projects that were active in 2002 addressed health care for chronic diseases and conditions that are especially common in the elderly. For example, in the Investigator-Initiated Research (IIR) program, 17 projects focus on treatment and outcomes for cardiac disease, including congestive heart failure, hypertension, ischemic heart disease, and pulmonary disease. Two IIR projects focus on cancer, emphasizing colorectal cancer screening and skin cancer outcomes. Additional IIR projects as well as projects funded under other HSR&D programs such as the Nursing Research Initiative and QUERI address health care for depression, diabetes, pressure ulcers, dementia, and other conditions for which elderly veterans seek or receive care. In this research, HSR&D investigators examine access to care, clinical decision making, health care costs, utilization patterns, and a wide range of patient outcomes, including quality of life and functional status.

Several ongoing Service-Directed Research (SDR) projects focus on issues relevant to aging veterans. These include diabetes care and guidelines education and training for physicians managing post myocardial infarction cardiac patients.

In FY 2003, the management consultation program funded four studies related to aging. Three were funded at the request of VA's Office of Geriatrics and Extended Care and are related to the Veterans Millennium Health Care and Benefits Act (PL 106–117). These three studies address the following topics:

- demonstrating three models of long-term care
- evaluating the use of assisted living services for elderly veterans as an alternative to nursing home care
- determining the effect of PL 106–117 on costs and access to VHA extended care

An unrelated study evaluates a demonstration hospice program. Interim results indicate that this delivery model can expand access to hospice care for veterans while maintaining quality of services.

B. HSR&D Research Centers and Programs

HSR&D's Center of Excellence conduct research and support the integration of research and practice. Six centers are currently conducting research on issues that directly involve an elderly veteran study population.

The Northwest Center for Outcomes Research in Older Adults in Seattle, Washington, has as one of its foci the preservation of independence in older adults. Research on aging addresses chronic diseases that are common among the elderly, including heart disease, depression, chronic obstructive pulmonary disease, and diabetes; diagnosis and treatment of osteoporosis; predictors of community residential care outcomes; and facilitating use of advance care directives by older adults. The Center for Health Quality, Outcomes and Economic Research based in Bedford, Massachusetts, emphasizes research related to improving the quality of health care for elderly veterans. Ongoing projects focus on the quality of long-term

care and seizures in the elderly. The Center for Practice Management and Outcomes Research in Ann Arbor, Michigan, emphasizes outcomes research and studies to improve the quality of clinical practice. Aging research at the Ann Arbor Center addresses quality improvement, especially on issues related to diabetes care. The Sepulveda, California, Center for the Study of Healthcare Provider Behavior seeks to build a knowledge base that will help researchers, policymakers, and health care managers design, implement and evaluate policies and programs to improve health outcomes. Research relevant to aging addresses interventions for delivering quality care to the elderly, improved adherence to smoking cessation guidelines, pressure ulcers, and delivery of care for vulnerable elderly groups such as veterans with Alzheimer's and Parkinson's Disease. The Center for Chronic Disease Outcomes Research at Minneapolis, MN, has a broad-based research portfolio, with programs in prevention, treatment outcomes, quality of care, and gender issues. HSR&D research underway at Minneapolis includes a comparison of the effectiveness of prostate cancer screening education tools, osteoporosis treatment and prevention, and strategies to improve smoking cessation. The Rehabilitation Outcomes Research Center for Veterans with Central Nervous System Damage in Gainesville, Florida, focuses on veterans who have suffered central nervous system damage as the result of stroke. Topics include evaluating the benefit of technology for elderly patients and utilization of community-based nursing homes.

In addition to the activities of the CoEs, HSR&D funds REAPs and TREPs that have a specific focus on aging. The Tampa REAP conducts research pertaining to safe mobility for frail elderly and persons with disabilities and the San Francisco REAP has as its core mission improving care for older veterans. In addition, the Denver TREP has a research agenda focused on improving the quality of long-term care for veterans.

Medical Research Service

Medical Research Service (MRS) funds basic and clinical research on the etiology, pathogenesis, diagnosis and treatment of diseases relevant to veterans. As the veteran population ages, much of our research is dedicated to understanding the aging process and the relation of the aging process to onset and treatment of disease. During 2002 MRS funded 446 aging research programs at a cost of $50.9 Million.

The MRS portfolio in aging research is very strong considering the expanse of topics covered and the different types of programs funded. Virtually all research portfolio areas within MRS include studies related to the aging process or diseases of aging. Recently, special emphasis has been made in attracting scientists to aging research; in fact, the mentored training awards are funded at a cost of $3.75 million, representing a significant investment in future aging research. The following are topical summary statements relative to the portfolio areas supporting aging research:

- Fifteen programs are devoted to understanding cellular senescence, metabolic changes with age, and difference in the musculoskeletal system.

- Efforts in neuroscience related to aging include 167 ongoing programs. 93 Merit Review awards are focussed on the neural substrates of neurodegenerative diseases prominent with increasing age: cellular functioning, factors influencing the advance of neurodegeneration, and ways to decrease cell death. Many of our REAPs have a specific focus on Parkinson's disease, stroke, Alzheimer's disease, and ischemia.
- $3 Million in research support funds immunology research relative to aging, with a particularly strong emphasis on arthritis. The majority of investigative efforts are directed at understanding the mechanisms of immune response, regulation, mediators involved and the signaling pathways via which the mediators exert their biologic effect.
- In the area of oncological disorders, MRS funds a high number of programs in prostate disease, with $5.0 Million in funding. The focus of the various programs on prostate cancer is very diverse, but includes more sensitive screening techniques and delineating basic mechanisms by which prostate cancer frequently metastasizes to the bone with the hope of developing and testing effective therapies to prevent cancer spread. Other ongoing research in oncology is directed towards understanding the relationship between age and skin cancer, and the basic biology of colon cancer.
- The endocrine research program related to aging remains strong, with $10.4 million dollars in 2002. This area of research is particularly pertinent as it encompasses the regulational changes affecting many areas, e.g. bone, metabolism, obesity, etc. Studies are directed to delineating the cellular basis of bone formation, regulation, and density; assays and function of hormonal systems, and osteoarthritis.
- Diseases of the cardiopulmonary system are being supported at a cost of $13.3 million. These studies include the use of state-of-the-art biochemical, molecular and genetic approaches to understand atherosclerotic plaque formation and ischemic injury and basic electrophysiology research. Some promising new approaches being studied by VA investigators in this area include tissue engineering, multisite pacing, and measurement and activation of brain natriuretic peptide (BNP).
- $3.8 million is directed to behavioral and psychiatric disorders studies related to aging, including cognitive status in neurodegenerative disease, aging brain function, age-dependent effects of alcohol, sleep disorders, and depression that may accompany disease such as coronary heart disease or bone loss.

Rehabilitation Research and Development Service

Rehabilitation Research and Development (Rehab R&D) is an intramural program for improving the quality of life of impaired and disabled veterans through a full spectrum of research activities. As the population of aging veterans with chronic disease expands, in part because of improved survival following catastrophic events, the need for research increases. Rehabilitation's fundamental clinical goal is to maximize functional recovery, which often means teaching compensatory techniques and providing adaptive tech-

nology. The long-term effects on outcomes of many traditional approaches remain unproven and, as rehabilitation moves forward, researchers must examine efficacy to allow medical practice to be truly evidence-based.

This is why nearly 75 percent of Rehab R&D's portfolio of funded projects relates to some aspect of aging. This includes neurological disease, spinal cord injury, mobility issues, prosthetic and orthotic devices, orthopedic interventions, communication disorder interventions, as well as sensory and cognitive aids. Centers of excellence and a community of scientists, clinicians, and engineers are engaging in innovative research that will not only assist veterans to manage their disease and impairment, but also play an integral role in restoring function. In addition to supporting scientific inquiry, Rehab R&D cultivates partnerships with nationally recognized organizations such as the Rosalynn Carter Institute for Human Development, National Institutes of Health, and National Science Foundation to sponsor consensus conferences and seminars to set the research agenda in rehabilitation medicine.

A. Centers of Excellence

Eight of twelve centers of excellence are the sites of innovative rehabilitation research seeking solutions to the needs of aging veterans with disabilities. Within each center Investigators and clinicians, in complimentary research areas, conduct collaborative studies to create multidimensional rehabilitation solutions. Across the nation, our investigators and clinicians are working on tangible ways to enhance aging veterans' quality of life. The eight centers of excellence are:

Vision/Hearing Loss

Two Rehabilitation Research Centers currently focus on low vision. The Atlanta center has recently narrowed its focus to rehabilitation for aging veterans with vision loss. Their work includes establishing outcome measures for blind rehabilitation therapies and incorporating orientation and mobility techniques into diverse physical environments. The Boston center brings nanotechnology expertise to the science of developing retinal prostheses for persons with age-related macular degeneration. Investigators are committed to restoring vision, minimizing invasive surgery, and optimizing ophthalmic care.

Investigators at the Portland center have contributed to current guidelines associated with early detection of hearing loss due to ototoxicity and are respected for their therapeutic work in ameliorating tinnitus. Other areas of work include establishing parameters for hearing aid use and developing methods of creating public awareness for preventing hearing loss.

Mobility

At the Human Research Engineering Laboratories in Pittsburgh, investigators are dedicated to transferring research findings into devices and clinical practices, which serve the mobility needs of veterans. Wheelchair manufacturers, government agencies, and consumer organizations utilize Pittsburgh's wheelchair-testing program to improve wheelchair design. Currently, investigators in col-

laboration with the Atlanta research center, are developing a robotic walker for frail elderly with visual impairment. The device uses sensor information combined with user input to negotiate safely around obstacles.

Arthritis

Arthritis is a common skeletal disease in the elderly and annually costs the U.S. more than $55 billion for treatment. For these reasons, researchers at the Center for bone and joint rehabilitation in Palo Alto, focus on preventing and restoring loss of function in individuals with osteo-, rheumatoid-, and traumatic-arthritis. Their efforts include the identification of new design concepts for longer lasting joint replacements, cartilage repair and regeneration, and the development and evaluation of devices and therapy protocols.

Stroke

Constraint-induced therapy to recover function after stroke is a promising rehabilitation therapy for stroke and other paralyzing disease states. Researchers are capitalizing on new knowledge about brain plasticity to bring about recovery in paralyzed limbs through forced use. However, appropriate timing of therapy, intensity of therapy, and adjunct pharmacotherapies are all open-ended questions. Researchers at the Gainesville center are addressing these issues. They work closely with the Rehabilitation Outcomes Center for Stroke, jointly funded through VA Health Services Research and Development and Rehab R&D.

B. Research Enhancement Award Program

The Research Enhancement Award Program (REAP) supports collaborations between funded VA investigators with complimentary backgrounds, skills, and training. They function in ways similar to a center, but on a small scale.

The Tampa VA has a REAP focused on technology to prevent adverse events in rehabilitation directed toward patient safety and solutions to manage patient falls, pressure ulcers, and pain. These area impact both veterans with disabilities and those who have disabilities as a consequence of aging. Data derived from this REAP could identify low- and high-technology solutions to significantly reduce adverse events in rehabilitation, speed a patient's recovery, and decrease healthcare costs.

A tissue engineering-based rehabilitation REAP located at the Boston VA will build on tissue culture, molecular biology, and collagen and proteoglycan biochemistry research. Investigators hope to develop a method for tissue and organ regeneration, which would supplant the use of prosthetic and orthotic devices. This would aid veterans affected by traumatic injury, disease, or aging. Tissue and organ regeneration holds promise to revolutionize rehabilitation and provide opportunities for more complete recovery.

A REAP in Mountain Home, TN adds a great deal to Rehab R&D's portfolio in hearing loss and vestibular dysfunction. Understanding speech in adverse listening environments is a major problem for those with hearing loss. Researchers want to gain a more complete understanding of this problem and developing solutions to overcome it. As with hearing loss, vestibular dysfunction, which

can be manifested as dizziness and balance problems, also affects the aging veteran population. Researchers are exploring therapies to ameliorate this problem.

C. Office of Academic Affiliations

All short- and long-range plans for the Veterans Health Administration (VHA) that address the healthcare needs of the Nation's growing population of elderly veterans include health professional training activities supported by the Office of Academic Affiliations (OAA). Clinical experiences with geriatric patients are an integral part of healthcare education for approximately 76,000 HVA health trainees, including 28,000 resident physicians and fellows, 16,000 medical students, and 32,000 nursing and associated health students. Each year these residents and students train in VA medical centers as part of affiliation agreements between VA and nearly 1,000 health professional schools, colleges, and university health science centers. Recognizing the challenges presented by the increasing size of the aging veteran population, VHA continues to promote, coordinate, and support geriatric education and training activities for physicians, dentists, nurses and other associated health professional trainees.

GERIATRIC MEDICINE

The VA healthcare system offers clinical, rehabilitation, and follow-up patient care services as well as education, research, and interdisciplinary programs. These constitute core elements required for the training of physicians in geriatric medicine. The demand for physicians with special training in geriatrics and gerontology is growing because of the rapidly growing numbers of elderly veterans and aging Americans.

Since the last Congressional Report in 1999, OAA has continued its support for Accreditation Council for Graduate Medical Education (ACGME)—accredited subspecialty training in geriatric medicine and geriatric physchiatry. In AY 2002, OAA supported 176 geriatric medicine positions and 27 geriatric positions.

In addition to its ongoing support for geriatric medicine and geriatric psychiatry positions, OAA began a new Special Fellowship in Advanced Geriatrics in AY 2000. This program is for post-residency physicians who have completed ACGME-accredited subspecialty residency training in geriatric medicine or geriatric psychiatry and want to lead geriatrics in academic centers and health systems. Fellows receive two years of additional training in geriatric research, advanced education, and advanced clinical care. Fellows spend approximately 75 percent of their time in geriatrics research and education and 25 percent in advanced clinical care.

In AY 2002, OAA supported eight fellows at five Geriatric Research, Education, and Clinical Center (GRECC) sites. During the last year, OAA also supported a total of 12 physicians pursuing post-residency fellowship education in geriatric neurology.

NURSING AND ASSOCIATED HEALTH PROFESSIONS

Based on its large number of elderly patients, VA offers all affiliated students clinical opportunities in the care of the elderly. VA also has special programs that focus on geriatrics.

GERIATRIC EXPANSION PROGRAM AND THE GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTERS (GRECC)

A special priority for geriatric education and training is recognized in the allocation of associated health training positions and funding support to VAMCs hosting GRECCs and to VAMCs offering specific educational and clinical programs for the care of older veterans. In FY 2002, a total of 229 associated health students received funding support in the following disciplines: Social Work, Psychology, Audiology/Speech Pathology, Clinical Pharmacy, Advanced Practice Nursing, Dietetics, and Occupational Therapy.

POSTDOCTORAL PSYCHOLOGY FELLOWSHIP PROGRAM

In 2002-2003, the psychology postdoctoral fellowship program at six facilities offered geropsychology as an area of emphasis for eight fellows. In addition, five facilities offered neuropsychology as an area of emphasis for five fellows. Much of the neuropsychology content relates to the care of elderly veterans.

INTERPROFESSIONAL FELLOWSHIP PROGRAM IN PALLIATIVE CARE

In AY 2002, VA facilities at six location (Bronx, Los Angeles, Milwaukee, Palo Alto, Portland, and San Antonio) initiated the new Interprofessional Fellowship Program in Palliative Care. This is the first interprofessional palliative care fellowship program in the country. The Palo Alto facility was selected as the hub site to coordinate fellowship activities across all sites. Each fellowship site is allocated four full-time equivalent paid trainee positions with no more than two positions being post-residency physicians. In AY 2002, seven physicians, seven nurses, three psychologists, nine social workers, two chaplains, and one pharmacist were fellows for a total of 29 fellows.

SUMMARY OF TRAINING IN GERIATRICS

Through its fellowship, residency, and associated health training, VA continues to make outstanding contributions to the Nation's health professions workforce and to foster excellence and leadership in the care of elderly veterans.

D. OFFICE OF EMPLOYEE EDUCATION

The Employee Education System (EES) supports the mission and vision of the Department of Veterans Affairs by offering a variety of learning opportunities to personnel working in the specialty of geriatrics and extended care. The goal of such learning activities is to enhance the care delivered to the elder VA patient by increasing the skills and knowledge of VA staff that provide care to the geriatric population. EES works in collaboration with VA Central Office, VISN (Veterans Integrated Service Network), and VA medical center staff to develop educational initiatives that are relevant and

responsive to the needs of the healthcare professionals throughout the system. EES provides funding for programs at the local, VISN and national levels.

During the past year, EES supported approximately 52 national, medical center, and VISN level programs in geriatrics and provided services and products in the specialty. While several programs have been interdisciplinary in nature, collaborating with mental health and primary care, the geriatric component has been a major focus. Programs that have had a system-wide scope include, but are not limited to, the following: Hospice and Palliative Care Education, Care Issues in Alzheimer's Disease and Other Dementing Illnesses, Community Nursing Home Programs: Introduction to Oversight Standards, Community Residential Care, Geriatric Skills in a Community Based Outpatient Clinic Setting and Late Life Cognitive and Geriatric Disorders. Also during 2002, EES worked closely with the Office of Geriatrics and Extended Care in their efforts to place emphasis on end of life programs to prepare VA staff in providing quality care to veterans in this transitional stage of life.

E. Chief Information Office

office of communications

The widespread education and training activities in geriatrics have generated system wide requirements for information throughout VA. Local library services continue to perform hundreds of online searches on databases such as MEDLINE and other bibliographic databases, and continue to add books, journals, and audiovisuals on topics related to geriatrics and aging. During FY2000, two titles on geriatrics were purchased and distributed to the VA Library Network (VALNET).

III. Veterans Benefits Administration

A. Compensation and Pension

Disability and survivor benefits such as pension, compensation, and dependency and indemnity compensation administered by the Veterans Benefits Administration (VBA) provide all, or part, of the income for 1,463,350 persons age 65 or older. This total includes 1,074,519 veterans; 381,592 spouses; 6,495 mothers; and 744 fathers as of end of month September 2002.

The Veterans' and Survivors' Pension Improvement Act of 1978, effective January 1, 1979 provided for a restructured pension program. Under this program, eligible veterans receive a level of support meeting a national standard of need. Pensioners generally receive benefits equal to the difference between their annual income from other sources and the appropriate income standard. Yearly cost-of-living adjustments (COLAs) have kept the program current with economic needs.

This Act provides for a higher income standard for veterans of World War I or the Mexican Border Period. This provision was in acknowledgment of the need for economic security of the nation's oldest veterans. The current amount added to the basic pension rate is $2,197 as of December 1, 2002.

B. OUTREACH

VBA Regional Office personnel maintain an active liaison with local nursing homes, senior citizen homes, and senior citizen centers in an effort to ensure that older veterans and their dependents understand and have access to VA benefits and services.

This liaison is enhanced by VA's Fiduciary Program. VBA Regional Office staff provide oversight in the management of VA benefits paid on behalf of incompetent beneficiaries. Many of these beneficiaries are elderly and have been found mentally incapable of handling their financial affairs. This oversight includes appointment of a fiduciary and supervision of the fiduciary and beneficiary, which includes periodic personal visits with the beneficiaries to ensure that their needs are being met and VA funds are being used properly.

Regional office staff visit these facilities as needed or when requested by the service providers. VA pamphlets and application forms are often provided to the facility management and social work staff during visits. State and Area Agencies on the Aging have been identified and are provided pamphlets and other materials about VA benefits and services through visits, workshops and pre-arranged training sessions. When requested, senior citizen seminars are conducted for nursing home operations staff and other service providers who assist and provide service to elderly patients. Regional office staff participate in senior citizens fairs and information events, thereby visiting and participating in events where the audience is primarily elderly citizens. Regional office outreach coordinators continue to serve on local and state task forces and represent VA as members of special groups that deal extensively with the problems of the elderly.