

DEVELOPMENTS IN AGING: 1991
VOLUME 2—APPENDIXES

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 62, SEC. 19(b), FEBRUARY 28, 1991

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



MARCH 12 (legislative day, JANUARY 30), 1992.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1992

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC, February 29, 1992.

Hon. J. DANFORTH QUAYLE,
President, U.S. Senate,
Washington, DC.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 62, agreed to February 28, 1991, I am submitting to you the annual report of the U.S. Senate Special Committee on Aging, Developments in Aging: 1991, 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 1991 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,

DAVID PRYOR, *Chairman.*

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MARCH 12 (legislative day, JANUARY 30), 1992.—Ordered to be printed

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

REPORT
APPENDIXES

APPENDIX 1

ANNUAL REPORT OF THE FEDERAL COUNCIL ON THE
AGING

DECEMBER 19, 1991.

DEAR MR. CHAIRMAN: On behalf of the Federal Council on the Aging, I am pleased to submit a preliminary summary of the 1991 annual report.

This document examines the history and present membership of the Council. It also highlights the various positions taken by the Council on a number of legislative and other issues concerning the well-being of the elderly. We are hopeful that the Council's view will be considered as the One Hundred and Second Congress reconvenes.

We appreciate the continuing interest of the Special Committee on Aging and look forward to another year of cooperative efforts with committee members and staff toward our mutual goal of service to older Americans.

Sincerely,

INGRID C. AZVEDO, *Chairman.*

SUMMARY OF THE 1991 ANNUAL REPORT

I. INTRODUCTION

A. BACKGROUND

The Federal Council on the Aging (FCoA) is the functional successor to the earlier and smaller Advisory Council on Older Americans, which was created by the 1965 Older Americans Act. In 1973, when the FCoA was created, Congress was concerned about Federal responsibility for the interests of older Americans, and the breadth of

vision that such responsibility would reflect. Having decided to upgrade the existing advisory committee, Congress patterned the legislative language authorizing the FCoA after the charter of the U.S. Commission on Civil Rights.

The FCoA is authorized by Section 204 of the Older Americans Act, as amended. The Council is composed of 15 members—appointed five members each by the President, the House of Representatives, and the Senate. Council members, who are appointed for 3-year terms, represent a cross-section of rural and urban older Americans, national organizations with an interest in aging, business and labor, and the general public. According to statute, at least nine members must themselves be older individuals.

The President selects the Chairperson of the Council from the appointed members. The FCoA is mandated to meet at least quarterly, and at the call of the Chairperson.

Functions of the Council include:

- Continually reviewing and evaluating Federal policies and programs affecting the aging for the purpose of appraising their value and their impact on the lives of older Americans;
- Serving as spokesperson on behalf of older Americans by making recommendations about Federal policies regarding the aging and federally conducted or assisted programs and other activities relating to or affecting them;
- Informing the public about the problems and needs of the aging by collecting and disseminating information, conducting or commissioning studies and publishing their results, and by issuing reports; and
- Providing public forums for discussing and publicizing the problems and needs of the aging and obtaining information relating to those needs by holding public hearings and by conducting or sponsoring conferences, workshops, and other such meetings.

The Council is required by law to prepare an annual report for the President by March 31 of the ensuing year. Copies are distributed to Members of Congress, governmental and private agencies, institutions of higher education and individual citizens interested in FCoA activities.

Funds appropriated for the Council are included in the overall appropriation of the Department of Health and Human Services (DHHS). These funds are used to underwrite meetings of the Council, to support staff, and publish information tracts authorized by the Council.

The results of its public meetings and activities concerning issues and policies affecting older Americans are shared with the President, Congress, the Secretary of DHHS, the Commissioner of the Administration on Aging (AoA), National and State Aging organizations, and other interested in the well-being of older Americans.

B. MEMBERS OF THE FEDERAL COUNCIL ON THE AGING

Ingrid C. Azvedo, Elk Grove, CA.—Chairman—Appointed to a three year term ending in January 1992, Mrs. Azvedo was appointed to her second term as Council Chairman by President Reagan in 1989.

Mrs. Azvedo has been advocating for senior programs through the California legislature and Governor's office for many years. She maintains an active schedule of speaking engagements throughout the State of California, discussing senior issues and programs both in the private and public sectors. She has also served on the Governor's Task Force on Long-Term Care and as a Commissioner on the California Commission on Aging. Currently, she serves as an Associate Justice on the California Unemployment Insurance Appeals Board.

Oscar P. "Bob" Bobbitt, Austin, TX.—Upon the recommendation of House Majority Leader Jim Wright, Mr. Bobbitt was appointed by House Speaker "Tip" O'Neill to a second 3-year term which ended in May 1991. In February 1984, he became executive director of the Texas Department on Aging, and served in that capacity until March 1990.

June Allyson, Los Angeles, CA.—Appointed to a 3-year term ending in January 1992 by President Reagan, Ms. Allyson has been an actress working through the Jerico Group in Los Angeles since 1944.

Virgil S. Boucher, Peoria, IL.—Appointed to a 3-year term ending in July 1993 by Speaker of the House Thomas Foley on the recommendation of House Minority Leader Robert Michel, Mr. Boucher is an active advocate for programs dealing with crimes against the elderly.

Robert L. Goldman, Oklahoma City, OK.—Appointed to a 3-year term ending in October 1993 by the President Pro-Tempore of the Senate upon the recommendation of Minority Leader Robert Dole. Since retirement from the Bell System in 1979, Mr. Goldman has been an active advocate for improving the quality of life

for older Americans. He is a member of the boards of numerous senior advocacy and service organizations, and maintains an intergenerational interest by working with handicapped school children. Currently, Mr. Goldman serves as Chairman of the Oklahoma State Council on Aging, Vice President of the Oklahoma State Board of Nursing Homes, and as a member of the Oklahoma State Commission on Health Care.

Tessa Macaulay, Deerfield Beach, FL.—Appointed by House Speaker Foley to a second 3-year term ending in August 1992. Ms. Macaulay is Coordinator of Gerontological Programs at Florida Power & Light Co.

Mary J. Majors, Cedar Falls IA.—Appointed by the President Pro-Tempore of the Senate upon the recommendation of Minority Leader Robert Dole to a second 3-year term ending in February 1992. Mrs. Majors was retired and active in all types of volunteer work. Mrs. Majors passed away in April 1991.

Josephine K. Oblinger, Springfield, IL.—Appointed by Speaker of the House Thomas Foley on the recommendation of House Minority Leader Robert Michel to a second 3-year term ending in March 1992. Mrs. Oblinger has had an extensive career as a State Legislator. Currently, she is Director of Senior Involvement in the Office of Governor James Edgar.

Kathleen L. Osborne, Los Angeles, CA.—Appointed by President Reagan to a 3-year term ending in January 1992. Ms. Osborne served as executive assistant to and office manager for President Reagan until June 1991. She is currently an agent with Coldwell Banker Real Estate Co. in Sacramento, CA.

Raymond Raschko, Spokane, WA.—Mr. Raschko was appointed on August 11, 1989, by House Speaker Foley to serve the remainder of a 3-year term ending in July 1990, and was appointed to serve a full 3-year term ending in July 1993. Mr. Raschko serves as Director of Elderly Services with the Spokane Community Mental Health agency, and as a member of the Washington State Long-Term Care Commission. He also serves as Director of the Greater Spokane Chapter of the Alzheimer's Association.

Patricia A. Riley, Brunswick, ME.—Appointed by the President Pro-Tempore of the Senate upon the recommendation of Senate Majority Leader George Mitchell to a 3-year term ending in May 1992. Ms. Riley is currently President of the nonprofit Center for Health Policy Development and executive director of its affiliate, the National Academy for State Health Policy. She previously served as Director of the Bureau of Maine's Elderly and its Bureau of Medical Services. She has served as a member of the American Bar Association's Commission on Legal Problems of the Elderly, and is currently on the Kaiser Commission on Medicaid Reform.

Gloria Sherwood, Beverly Hills, CA.—Appointed to a 3-year term ending in December 1990 by President Reagan. Ms. Sherwood is currently a mental health practitioner in private practice in Los Angeles, California, and a broker affiliate and manager of the Residential Leasing Division of the Prudential California Realty Company.

Norman E. Wymbs, Boca Raton, FL.—Appointed to a 3-year term ending in January 1992 by President Reagan. Mr. Wymbs is a former Mayor of the City of Boca Raton. He has been Chairman of a District Mental Health Board and of the Boca Raton Housing Authority. An elected official of the Florida Republican Party for 14 Years, Mr. Wymbs is the author of "A Place to Go Back To", a biography of Ronald Reagan's boyhood, and "Sold to the Highest Bidder", a treatise on Washington political financing. He currently serves as Chairman of the nonprofit Ronald Reagan Home Foundation, Inc.

E. Don Yoak, Spencer, WV.—A native of West Virginia, Mr. Yoak was appointed in July 1989 by the President Pro-Tempore of the Senate upon the recommendation of Senate Majority Leader Robert C. Byrd to a 3-year term ending in July 1992. He is retired from the West Virginia Department of Highways and has been active in West Virginia Legislatures for the last 50 years. Mr. Yoak currently serves as Doorkeeper of the West Virginia House of Delegates and as a member of the AARP Citizen Representation Program, which is designed to coordinate governmental agencies with seniors to serve on councils, commissions, boards, and advisory panels.

Virginia Zachert, Augusta, GA.—Appointed to a 3-year term ending in March 1993 by the President Pro-Tempore of the Senate upon the recommendation of Senate Majority Leader George Mitchell. Dr. Zachert holds a Ph.D. in industrial psychology. She currently serves with the Georgia Silver Haired Legislature as President of the Senate and Chairman of the Board of Directors, and is a member of the Georgia Council on Aging. Dr. Zachert has published numerous articles in the fields of medical teaching and aging. She is a former Federal em-

ployee and Professor Emerita of the Department of OB-GYN of the Medical College of Georgia.

During 1991 three members were newly appointed to the Council:

Eugene S. Callender, New York City, NY.—Appointed by House Speaker Foley to a 3-year term ending in June 1994. Dr. Callender was appointed by the Governor as Director of the New York State Office for the Aging in 1983. Currently, he co-chairs the Governor's Long-Term Care Policy Coordinating Council, and is vice chairperson of the National Council and Center for Black Aged.

Dr. Callender has served in numerous governmental, academic, and religious capacities at the local, State, and Federal levels, dealing with such issues as housing, manpower, income security, and urban issues.

Connie Hadley, Kansas City, KS.—Appointed by the President Pro Tempore of the Senate upon the recommendation of Minority Leader Robert Dole to serve the remainder of the term of Mary Majors, which expires in February 1992. Mrs. Majors passed away in April 1991.

Mrs. Hadley is an active senior with a long involvement in community programs. A respected and influential voice in the community, she is especially active in promoting programs to help the low-income and minority elderly. She is a former Executive Director of the Economic Opportunity Foundation, Inc., in Kansas City, and is a member of Senior Organized Citizens of Kansas. She also serves on the board for Foster Grandparents in Wyandotte County, and was the first County Senior Citizens Coordinator.

Bernard M. Barrett, Jr., M.D., Houston, TX.—Appointed by President Bush on November 13, 1991, Dr. Barrett currently serves as Chairman of the Texas Institute of Plastic Surgery and as attending surgeon at St. Luke's Episcopal Hospital in Houston.

C. CALENDAR 1991 MEETING DATES

The Council met four times during the year 1991, as required by the Older Americans Act. The meeting dates were January 31-February 1, March 21-22, June 11-12, and November 13-14. The meetings were held in Washington, D.C.

All FCoA meetings were announced in the Federal Register and notices of the meetings sent to representatives of national organizations, staff of various Federal agencies, and to Congressional members and committees interested in or responsible for aging. Minutes are distributed to individuals who attended the meetings and to any interested parties who request them. Publications and documents pertinent to official actions are maintained in the Office of the Federal Council on the Aging and are available to the general public. The FCoA mailing address is: Room 4280, Wilbur J. Cohen Federal Building, 330 Independence Avenue, S.W., Washington, D.C. 20201-0001.

D. COUNCIL MEETINGS SCHEDULED FOR CALENDAR 1992

Current plans call for the Council to meet in 1992 as follows: February 26-27; May 13-14; August 12-13; and November 18-19.

II. ACTION OF THE FEDERAL COUNCIL ON THE AGING DURING CALENDAR YEAR 1991

A. AGING AMERICA: TRENDS AND PROJECTIONS

The FCoA participated for the third time in the development, printing and distribution of the demographic report—"Aging America: Trends and Projections, 1991 Edition." The publication is a cooperative effort with the Administration on Aging, the Senate Special Committee on Aging and the American Association of Retired Persons (AARP).

B. REAUTHORIZATION OF THE OLDER AMERICANS ACT

The Council finalized their recommendations for the Reauthorization of the Older Americans Act of 1965. Once the Council completed final action on their recommendations, they were forwarded to the President and the Congress for consideration.

C. MENTAL HEALTH AND THE ELDERLY

To continue with their focus on Mental Health Issues confronting the elderly which began with their November 1990 Symposium on the issues, the Council is conducting a comprehensive study of Mental Health and the Elderly, with the assistance of the National Institute on Mental Health (NIMH). The Council's 1980

publication *Mental Health and the Elderly: Recommendations for Action*, will serve as a starting point for the new study.

D. NATIONAL ELDERCARE CAMPAIGN

The Federal Council on the Aging has taken an active role in the National Eldercare Campaign, launched this year by the U.S. Administration on Aging. The council has met regularly with the organizers of the initiative, closely monitored its progress, and advised the Commissioner on Aging on key issues in the Campaign Strategy. The Council will participate in the National Eldercare Campaign by examining the portrayal of the elderly in the media and the entertainment industry, and making recommendations to improve the image of the elderly which is conveyed.

E. MEMBERSHIP ACTIVITIES

In anticipation of the 20th Anniversary of the creation of the Federal Council on the Aging in 1993, the Council has been active in locating and communicating with former members of the Council. Also, the Council has worked to strengthen the orientation procedures for newly appointed members.

F. 1993 WHITE HOUSE CONFERENCE ON THE AGING

Throughout 1991, the Council closely monitored legislative and other developments regarding the 1993 White House Conference on the Aging.

G. LEGISLATIVE BRIEFINGS AND ACTIVITIES

During their January meeting, the Council attended a hearing of the Aging Subcommittee of the Senate Committee on Labor and Human Resources entitled "Protecting the Vulnerable Elderly: Is the Older Americans Act Doing its Job?" Discussion and testimony presented at the hearing provided insights which were very helpful in the Council's deliberations on recommendations for the Reauthorization of the Older Americans Act.

The first day of the Council's June meeting was held at the Dirksen Senate Office Building. Members were visited and briefed by several Congressional staff persons and a special presentation was provided by the Honorable John D. Rockefeller, IV, U.S. Senator from West Virginia and Chairman of the Pepper Commission.

III. FUTURE DEVELOPMENTS

A. PREPARATIONS FOR THE 1993 WHITE HOUSE CONFERENCE ON AGING

In accordance with provisions of the Older Americans Act which states:

"The Secretary shall establish an advisory committee to the Conference which shall include representation from the Federal Council on the Aging and other public agencies and private nonprofit organizations as appropriate" the Council will participate fully in the planning and preparation for a 1993 White House Conference on Aging, called by the President on June 3, 1991.

B. MENTAL HEALTH AND THE ELDERLY

The Council will continue work on the publication of a report on Mental Health Issues affecting the Elderly. Presentations provided at the November, 1990 Quarterly Meeting of the Council will form the basis for the report, which seeks to identify and encourage ways to improve coordination between the Aging and Mental Health Networks in improving access for the elderly to services provided by both networks.

C. LONG-TERM HEALTH CARE

The Council will continue to closely monitor progress in addressing the growing long-term health care needs of the Nation's ever-increasing older population, including the implementation of aspects of the recommendations issued by the U.S. Bipartisan Commission on Comprehensive Health Care (Pepper Commission) which were reviewed at the May 1990 Quarterly Meeting.

D. OLDER PERSONS LIVING ALONE

The Council will investigate the unique issues and challenges facing older persons who live alone in their communities, with special emphasis on mental health issues which may arise in such situations.

E. BARRIERS TO ACCESS

The Council will identify and investigate various barriers which inhibit the access of older persons to supportive programs and services for which they may qualify, with particular emphasis on special populations including minorities, persons with low income, and persons with mental health problems. Included will be a review of various programs in place to eliminate such barriers.

F. OLDER PERSONS IN THE MEDIA

The Council will assess the nature and impact of the portrayal of older persons in the entertainment industry and other media, and the degree to which negative stereotypes of the elderly are perpetuated.

G. NATIVE AMERICAN ELDERS

The Council will review the status of issues facing Native American Elders which were the focus of their May 1987 hearings in South Dakota, and assess the progress that has been made.

IV. COUNCIL RECOMMENDATIONS

A. REAUTHORIZATION OF THE OLDER AMERICANS ACT

During their January meeting, the Council finalized action on their recommendations for reauthorization of the Older Americans Act as follows:

1. States shall develop intrastate funding formulas with special consideration for older populations with the following characteristics: Low income, minority, 75 years and older, non-English speaking, and those living alone.

2. The Aging Network should be encouraged to concentrate on the development of programs which strengthen cooperative arrangements with private industry, community leaders, and organizations, and other institutions.

3. Section 311(a)(4) should be amended to require *annual* adjustment of USDA reimbursement increases which reflect changes in the Consumer Price Index.

4. All mandates for new programs should be accompanied by separate authorization and *adequate appropriations* to prevent any detrimental impact on currently funded services and programs.

5. Provisions of the Act which mandate or encourage interaction between the Administration on Aging and other Departments or agencies should be complemented and supported by companion language in the authorizing legislation of those agencies. This legislation should also compel those agencies' cooperation in efforts and activities of the Commissioner on Aging in pursuing the mandates concerning interdepartmental coordination which are stated in Title II, Section 203, of the Act.

6. *Section 204(a)(2) Current Law:* "Any member appointed to fill a vacancy occurring prior to the expiration of the term for which such member's predecessor was appointed shall be appointed only for the remainder of such term. Members shall be eligible for reappointment and may serve after the expiration of their terms until their successors have taken office."

Proposal: Add, "In such instances, the succeeding member's term expiration date shall remain March first of the third class year of the appointment."

7. *Section 204(b)(1)(A) Current Law:* "The members appointed in 1985 shall be referred to as class 1 members; the members appointed in 1986 shall be referred to as class 2 members; the members appointed in 1987 shall be referred to as class 3 members."

Proposal: Change "1985", "1986", and "1987" to "1991", "1992", and "1993", respectively. Also, add "The terms of the members and their successors, if any, shall expire on March first of the third year of their class term."

8. States shall seek to expand ombudsman services to improve the quality of community based and institutional care. State agencies shall seek to improve the quality of ombudsman services through establishing and implementing standards for services, continued and improved training of ombudsmen personnel, including trained and qualified volunteers.

9. Funding for AoA should be included as a separate line item in the HHS budget and should provide the Commissioner with maximum control regarding the agency's budget, including travel and personnel.

10. The Council supports the implementation of cost-sharing arrangements for services provided under the Older Americans Act. The two services which should be exempted from such new provisions are information and referral and

ombudsman services. In implementing such provisions, States should carefully consider the views of older persons and providers and take special care to not exclude vulnerable, low-income and minority older persons.

11. Basic gerontological and geriatric courses should be a *required* component of all Medical, and Psychological, Nursing, Allied Health, and Social Work training curricula.

AoA should enlist the support and assistance of the academic community, including the Department of Education, Universities and Colleges, Community Colleges, National Educational Organizations, and State and local public education systems and other related Federal programs to create an adequate supply of trained and qualified personnel to meet the service needs.

12. A new Title VII of the Act should be established to provide for State elder rights programs in order to assure that the elderly, particularly the most vulnerable, are afforded the full rights and protections of our society.

B. THE FEDERAL COUNCIL ON THE AGING: ITS BUDGET AND MANDATE

At their March meeting, the Council unanimously passed the following resolution regarding their mandate and funding level:

Whereas, The Federal Council on the Aging is mandated by the Older Americans Act of 1965, as amended, to:

- advise and assist the President and Congress relating to the special needs of older Americans;
- review and evaluate Federal policies, programs, and activities regarding the aging;
- serve as a spokesman on behalf of older Americans by making recommendations to the President, the Congress, the Secretary of Health and Human Services and the Commissioner on Aging;
- inform the public about the problems and needs of the aging;
- provide public forums for discussing and publicizing the problems and needs of the aging, and

Whereas, The Federal Council on the Aging has a unique and important role, representing older persons and bringing together the agencies of the Federal Government with the private sector, State and local governmental units, researchers, and practitioners to develop sound policies; and

Whereas, The older population of our society is increasing dramatically, creating a demand for additional attention to evolving needs and emerging issues, and,

Whereas, The appropriate functions of government are being reviewed and altered insofar as the needs of older people are concerned; and

Whereas, The Federal Council on the Aging has undertaken critical evaluation and published reports and recommendations to assist policymakers dealing with such central issues and problems as long-term care, housing, employment, guardianship, issues concerning Native American elders, mental health issues, nursing home reform, the Reauthorization of the Older Americans Act, and others, and

Whereas, The funding level for the Council has remained for a decade at a level initially established in 1982, allowing no adjustments for increases in expenses or inflation, and

Whereas, The funds for the work of the Council have been reduced to a level which severely limits the Council's capacity to fulfill its mandate to serve the President, the Congress, and our older citizens; therefore,

Be it resolved, That the Federal Council on the Aging urges the Congress to appropriate not less than \$500,000 for fiscal year 1992, a sum deemed by the Council as necessary to enable the Council to perform its role as mandated.

Be it further resolved, That the Federal Council on the Aging transmit to Members of the Congress this resolution and such other information as will assist the Members to review the work of the Council, its mission and functions; and to urge the Congress to reaffirm the mandate as defined in Section 204 of the Older Americans Act of 1965, as amended, for the Council; and advise the Administration of such action.

C. THE NATIONAL ELDERCARE CAMPAIGN

Also during their March meeting, the Council issued recommendations concerning the National Eldercare Campaign. Where appropriate, these recommendations were forwarded to the U.S. Commissioner on Aging:

1. The Task Force should establish a continuing dialogue with the Commissioner and the Strategy Team.
2. The Council should send a letter to the Commissioner expressing the support for the goals of the campaign and apprising her of the Council's recommendations and activities regarding the campaign.
3. As planning of the National Eldercare Campaign is completed, the Council urges caution to be cognizant of potential negative public reaction from those who feel they hear too much about the problems of the elderly, and not enough about plausible solutions to those problems.
4. Strongly recommend that the Administration on Aging plan a major announcement of the National Eldercare Campaign once it is fully conceived, and that President and Mrs. Bush be invited to take part in that announcement.
5. The Commissioner should convene a National Advisory Committee for the campaign, involving representatives of the Federal Council on the Aging, the Aging Network, the volunteer sector, labor organizations, and both large and small businesses.
6. Because the 10 proposed technical assistance centers are to provide help in addressing problems faced by older Americans, the Council urges that individuals selected to review proposals for the centers be broadly representative of the many communities they are to serve.
7. The Federal Council on the Aging should launch its own Eldercare project to support and compliment the Administration on Aging Campaign. Over the next several months, the Task Force will be examining ways to improve the image of older persons and aging in the media. Following consultation with experts in the field, we plan to issue a white paper and develop specific plans and proposals.
8. The Commissioner should be invited to future Council meetings to discuss the National Eldercare Campaign in further detail.

D. RECOMMENDATIONS TO CONFEREES CONSIDERING THE REAUTHORIZATION OF THE OLDER AMERICANS ACT

During their November meeting, the Council issued the following recommendations to congressional conferees considering the Reauthorization of the Older Americans Act:

1. While reaffirming its support for Older Americans Act Ombudsman Services as reflected in their January 1991 recommendation which states:

States shall seek to expand ombudsman services to improve the quality of community-based and institutional care. State Agencies shall seek to improve the quality of ombudsman services through establishing and implementing standards for services, continued and improved training of ombudsmen personnel, including trained and qualified volunteers.

However, the Council is strongly opposed to provisions in proposed legislation which would require enforcement with subpoena power in this area by the Administration on Aging.

2. The Council reasserts the concerns reflected in its March 1991 resolution concerning the level of funding and the mandate of the Council, and urges the conferees to include authorizing legislation in the Act which will accommodate this level of funding.

3. The Council strongly opposes Senate proposed language (Sec. 208) which would require evaluation of the Council by the Secretary of Health and Human Services. The Council finds this provision to be mutually exclusive of, and in direct conflict with, its mandate as stated in Sec. 204, particularly Sec. 204.d.2, which states:

[The Council shall] review and evaluate, on a continuing basis, Federal policies regarding the aging and programs and other activities affecting the aging conducted or assisted by all Federal departments and agencies for the purpose of appraising their value and their impact on the lives of older Americans.

4. The Council reaffirms its support for permitting cost-sharing arrangements for Older Americans Act programs and services as stated in their January 1991 recommendation:

The Council supports the implementation of cost-sharing arrangements for services provided under the Older Americans Act. The two services which should be exempted from such new provisions are information and referral and ombudsman services. In implementing such provisions, States should carefully consider the views of older persons and providers and take special care to not exclude vulnerable, low-income and minority older persons.

5. The Council strongly urges the conferees to retain and adopt language in the Senate proposal regarding the terms and appointment of members of the Federal Council on the Aging.

Current appointment practices to not provide clear expiration dates or uniform and predictable term rotation, particularly when members continue to serve while awaiting subsequent appointments which are not made in a timely manner.

This change would provide the predictable and uniform term rotation which was intended by the original legislation, but is lacking in current practice. Members often continue to serve beyond their term expiration due to untimely appointment by appointing authorities. When subsequent appointments are finally made, the new members' 3-year terms have been commenced as of the date notice of their appointment appears in the Congressional Record. This has resulted in a confusing array of appointment openings and expiration dates which significantly disrupts the efficient functioning of the Council. The object of this clarification is to render the terms "class specific" rather than "member specific."

Establishing orderly terms rotations will enhance the Council's ability to plan and adhere to a meaningful and productive agenda without unpredictable disruption due to loss of expertise or shifts in focus resulting from abrupt changes in membership.

E. RECOMMENDATIONS TO THE PLANNERS AND STAFF OF THE 1993 WHITE HOUSE CONFERENCE ON AGING

Also during their November meeting, the Council issued the following recommendations regarding the 1993 White House Conference on Aging:

1. The Council urges that organizers of the Conference maintain an acute sensitivity to the identification and elimination of physical barriers and obstacles which may hinder access to conference facilities, including the location of cables and cords used by the media.
2. While realizing the fiscal restraints under which the Conference will likely be conducted, the Council urges planners to make every possible effort to assure the participation of low income and minority elderly, as well as older persons who are in greatest social and economic need.

F. RECOMMENDATIONS TO CONDUCT A STUDY OF MENTAL HEALTH AND THE ELDERLY, WITH THE ASSISTANCE OF THE NATIONAL INSTITUTE OF MENTAL HEALTH

During its November meeting, the Council adopted the following guidelines regarding specific tasks and topics that are to be included in the planned study of Mental Health and the Elderly:

1. A review of the 1980 FCoA report on mental health and the elderly, the November 1990 FCoA symposium presentations, and other organizations and publications.
2. Report the incidence, prevalence, and future projections of problems involving mental health including dementias, alcohol and prescription drug abuse, and elder abuse among the elderly in community, institutional, and residential settings (i.e. congregate housing, foster care, assisted living facilities, nursing homes, and acute care facilities). This should also reflect rural and urban differences, if any.
3. An assessment of the current service and care delivery systems.
4. The relationship between the mental health and aging network, and the role of Area Agencies on Aging in mental health services.
5. Profiles of model programs for replication.
6. FCoA recommendations for action.
7. The report should be completed, printed, and distributed in 1992.

APPENDIX 2

REPORT FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1. DEPARTMENT OF AGRICULTURE

JANUARY 27, 1992.

DEAR DAVID: Enclosed are the Department of Agriculture's updates to Volume II of the Senate Special Committee on Aging annual report "Developments in Aging." We hope you will find this information useful as you compile the 1991 edition of the report.

Sincerely,

EDWARD MADIGAN, *Secretary.*

Enclosures.

AGRICULTURE RESEARCH SERVICE (ARS)

Title and purpose statement of each program of activity which affects older Americans

Studies are conducted at the USDA Human Nutrition Research Center on Aging (HNRC) at Tufts University, Boston, MA, which address the following problems of the aging:

1. What are nutrient requirements to insure optimal function and well being for a maturing population?
2. How does nutrition influence the progressive loss of tissue function associated with aging?
3. What is the role of nutrition in the genesis of major chronic, degenerative conditions associated with the aging process?

In addition, studies are performed at the Beltsville Human Nutrition Research Center (BHNRC), the Grand Forks Human Nutrition Research Center (GFHNRC), and the Western Human Nutrition Research Center (WHNRC) on the role of nutrition in the maintenance of health and prevention of age-related conditions, including cancer, coronary heart disease, hypertension and diabetes.

Brief description of accomplishments

HIGHLIGHTS OF RESEARCH FINDINGS RELATED TO NUTRITION AND PREVENTION OF DISORDERS ASSOCIATED WITH AGING

VITAMIN B6 REQUIREMENTS OF THE ELDERLY

The vitamin B6 requirements of elderly men and women (greater than 60 years) were studied using a depletion-repletion design. The protocol consisted of having subjects eat a diet deficient in vitamin B6 for 17-20 days and then feeding them diets containing increasing amounts of vitamin B6 over a period of 63 days. Biochemical tests for vitamin B6 status were done on blood and urine specimens collected during the period of vitamin B6-deficiency. The status gradually returned to normal during vitamin B6 repletion. The amounts of vitamin B6 that restored the biochemical tests to baseline (i.e., pre-depletion) values were considered the minimum vitamin B6 requirements. These were determined to be 1.96 mg/day for elderly men and 1.90 mg/day for elderly women. These values are greater than the minimum vitamin B6 requirements reported for younger adults.

VITAMIN B12 ABSORPTION IN ATROPHIC GASTRITIS

Poor absorption of food-bound vitamin B12 has been reported in atrophic gastritis, a common condition of aging which is characterized by reduced or no gastric acid output, as well as increased numbers of bacteria in the upper parts of the small intestine and the stomach. Food-bound vitamin B12 is poorly absorbed in atrophic gastritis subjects as compared to normal controls. It has been found that this poor absorption of vitamin B12 can be reversed by the administration of an antibiotic.

These findings suggest that the increased numbers of bacteria in the upper parts of the stomach and small intestine cause the poor absorption of food-bound vitamin B12 by binding the vitamin and using it for their own purposes. The poor digestion of food protein from vitamin B12 due to lack of acid seems to play only a minor role in causing the vitamin B12 malabsorption in this condition. Reducing the number of bacteria in the stomach and the upper intestine normalizes the poor absorption of food-bound B12.

EFFECT OF GASTRIC ACIDITY AND HIGH FIBER INTAKE ON CALCIUM ABSORPTION IN ELDERLY

Osteoporosis is a debilitating problem in the elderly that is associated with decreased absorption of calcium by the intestine. Some studies have suggested that inadequate amounts of gastric acid and diets high in fiber decrease calcium absorption. This is important because decreased production of gastric acid (achlorhydria) affects more than 24 percent of persons over age 60. Accordingly, the ability of the intestine to absorb calcium from test meals was measured in nine healthy elderly subjects and eight elderly subjects with achlorhydria. Healthy controls given a low-fiber meal (0.5 g) retained 26 percent of the calcium. A test meal high in fiber (10.5 g) reduced the amount of calcium absorbed to 20 percent. However, there was no difference in absorption of calcium between normal subjects or subjects with achlorhydria. Further, the addition of hydrochloric acid to the test meal to stimulate gastric acid did not change the absorption of calcium. This study shows that calcium is well absorbed from food and that its absorption does not depend on gastric acid. High fiber intake decreases the absorption of calcium. These data are important in determining calcium requirements in the elderly.

CATARACT PREVENTION—DEGRADATION OF PROTEINS IN CULTURED BOVINE LENS

In order for the lens to maintain clarity and transmit light to the retina, proteins that are no longer necessary for the lens cell or that are damaged must be degraded. If damaged proteins are not removed, there is a high probability that lens clouding and cataract will occur. A study was done to determine if the lens contains the enzymes necessary to degrade various lens proteins. Three proteins were chosen: (1) alpha crystallin, the major lens protein; (2) histone H2A, a component of the DNA machinery for protein synthesis; and (3) actin, a protein necessary for the movement and structure of lens cells. It was found that 26 percent of the histone H2A was broken down by lens cell enzymes, but only 2.5 percent and 3.3 percent of the alpha crystallin and actin, respectively, were broken down. This suggests that histone H2A is processed by the lens when it becomes obsolete, but that alpha crystallin and actin are required for the normal functioning of the cell and are not broken down as readily. Cells that can be grown in the laboratory have also been prepared from bovine lenses. Degradation of protein in these cells is used as a model for protein degradation in the lens. It was found that protein degradation capability is dependent on calcium in these cultured bovine lens cells. A specific calcium-dependent enzyme (calpain) has been identified in these cells.

NUTRIENT INTAKE AND SENILE CATARACT

Relatively little is known about factors which modify senile cataract risk even though cataracts are an important cause of disability. Care of patients with cataracts costs billions of dollars annually. Evidence that nutrition plays a role in the development of senile cataracts in humans is limited, but available data suggest that higher intakes of vitamins C and E and carotenoids may reduce cataract risk. To examine the role of nutrition in cataract formation, food consumption and vitamin supplement use were assessed in 77 persons with senile cataracts and 35 persons with clear lenses. Subjects who reported consuming less than 250 g of folate per day were 6 times more likely to have cataracts than subjects who reported consuming more than 725 g per day. Subjects reporting vitamin C intakes below 125 mg per day were 4 times more likely to have cataracts than subjects with intakes greater than 490 mg per day. Persons consuming 3.5 or fewer servings of fruits and vegetables per day were almost 5 times more likely to have cataracts than persons consuming more than 8.5 servings per day. Although these results are preliminary, they support existing evidence of a relationship between vitamin C and cataracts and indicate that further examination of the previously reported relationship between folate and cataracts is warranted.

NUTRITIONAL STATUS OF ELDERLY SMOKERS AND NONSMOKERS

Previous studies have suggested that smokers may have lower blood nutrient levels than nonsmokers due to some element in cigarette smoke which affects nutrient absorption or metabolism. In this study, both the diets and blood nutrient levels of 87 elderly smokers and 637 nonsmokers were examined. Differences in the nutritional status of the two groups were observed which were consistent with earlier research. Smokers' intakes of all nutrients except for vitamin B12 and folate were significantly lower than nonsmokers' intakes, after adjustment for age, sex, and total caloric intake. Lower blood levels of carotenoids, retinol, riboflavin, vitamin C, and magnesium and higher levels of calcium were seen in smokers compared to nonsmokers, after adjustment for age and sex. Differences in carotenoid and riboflavin levels persisted after adjustment for intakes of these nutrients. The majority of the differences in blood nutrient levels observed between smokers and nonsmokers can be explained by the poorer quality of the smokers' diets. It is likely that the small differences in intake which were observed would assume added importance in a population of elderly with marginal or inadequate nutritional status.

MAGNESIUM DEPRIVATION IN POSTMENOPAUSAL WOMEN

Because magnesium is crucial in more than 300 chemical reactions in the body, the dietary lack of it has been suggested as contributing to the cause of several human disorders, including ischemic heart disease, osteoporosis, and pregnancy complications. Although magnesium deficiency can be induced with relative ease in young experimental animals, deficiency has been found difficult to induce in humans. In fact, efforts to produce signs of magnesium deficiency in humans simply by restricting dietary intake have generally been unsuccessful. Thus, two experiments were performed with healthy postmenopausal women, since women at this stage are thought to have an increased need for magnesium. In both experiments, magnesium deprivation, or 109-115 mg/2,000 kcal, depressed plasma cholesterol and changed red blood cells in a manner which suggests an alteration in their membranes. The findings indicate that significant effects do occur from low dietary intakes of magnesium in healthy adults. Some women after 52 and 64 days on the low-magnesium diet showed heart rhythm abnormalities suspected to be caused by the low magnesium intake. In one experiment, a significant elevation in mean corpuscular volume and hemoglobin concentration was also observed with magnesium deprivation. These experiments help to define the importance of magnesium in human nutrition.

COGNITION-PSYCHOMOTOR ASSESSMENT SYSTEM

A computer software package, the Cognition-Psychomotor Assessment System, has been developed to automate the administration and scoring of over 20 tasks designed to assess psychological function in studies of nutrition. Tasks were adapted from neuropsychology and experimental cognitive psychology to permit assessment of attention, perception, learning, memory, and problem-solving processes, as well as sensory-motor and spatial skills. Scientists can evaluate performance, on a battery of tasks they select, in relation to nutritional status, or in response to dietary manipulations. This package of programs can be run on a microcomputer, providing the researcher access to a broad range of tasks, at far less cost than supplies and equipment necessary for manual administration and scoring. The system is menu-driven and provides help screens to facilitate use by novice and expert alike. In addition, utilities have been included for transfer of performance data to mainframe computers for analysis with commercial statistical packages. The system has been successfully applied to the study of nutritional effects on psychological function in adults.

COMPARISON OF VERY LOW-CALORIE FOODS VS. FORMULA REDUCING DIETS IN WOMEN

Very-low-calorie diets, generally less than 600 calories/day, have become popular when large amounts of weight loss are desired. However, information regarding the effects of these low-calorie diets on body composition and physical performance is limited. Therefore, a study was conducted with 21 obese women, fed either a meat/fish/poultry (MFP) low-calorie diet (450-600 cal/d) or a liquid formula (OPTI) diet (450 cal/day). Body composition and physical performance were assessed by standard underwater weighing and cycle ergometry procedures. Weight loss was similar for both groups: 24.5 kg for MFP and 26.7 kg for OPTI. Likewise, lean body mass (fat-free mass) losses were about the same: 4 kg for MFP and 5.4 kg for OPTI. How-

ever, the group fed the liquid diet showed a marked decline in physical performance after dieting while the women fed the meat-fish-poultry diet did not.

REFERENCE MAN AND WOMAN MORE FULLY CHARACTERIZED

Several methods exist to describe and analyze the various components of matter in living human beings. Total body neutron activation analysis, prompt-gamma neutron activation analysis, and whole body counting have been used in an adult U.S. population to determine the elemental composition of the human body. The elements measured were potassium, nitrogen, calcium, chlorine, and phosphorus. Total body water was determined by the dilution principle using stable isotope labeled water (tritiated). A total of 1,374 observations were made in adults ranging in age from 20 to 90 years. Age-, race-, sex-, and size-specific differences were evident. When equations were developed that predicted the elemental composition of the adult on the basis of age, weight, and height, variation in the age groups was up to 10 percent. Age-specific values for the 20- to 29-year-old white population were also compared with values for the International Commission on Radiological Protection Reference Man. The "average" young adult U.S. male is larger than Reference Man; the data also indicated a larger skeletal mass and more lean tissue and body water but less body sodium. However, when the *in vivo* prediction equations were used to adjust for size differences, good agreement was found between the expected values and for Reference Man. These data provide the first estimates of body composition for Reference Woman. These techniques can also be used to examine the effects of diet, growth, aging, or malnutrition in living infants and children.

ESTIMATION OF TOTAL BODY WATER IN AFRICAN-AMERICANS

Body composition is an important indicator of nutritional status. Bioelectric impedance analysis (BIA) is one of the newer methods used to assess body composition by clinicians, by national surveys teams, and by the Department of Defense. Bioelectric impedance analysis methodology has been developed largely using equations and data collected in European-American populations. Since several differences are known to exist between the body composition of African and European Americans, a study was designed to investigate the applicability of bioelectric impedance analysis in African-Americans, using prediction equations developed from European-Americans. A multiple regression equation developed with data from 79 European-Americans, using deuterium oxide dilution as the reference method, was applied to 88 African-Americans aged 19-50 years. There was good correlation between total body water estimates predicted by bioelectric impedance analysis with that determined using deuterium oxide ($r = 0.98$). It is concluded that bioelectric impedance analysis may be valuable in the assessment of body composition in African-Americans, although total body water was slightly underestimated using equations from European-Americans. This may be due to racial differences in body composition; hence race-specific equations were developed. These equations will be useful in further studies by other scientists or agencies. This noninvasive, simple technique can be used to assess the nutritional status of elderly people who cannot tolerate other methods.

BODY COMPOSITION ASSESSMENT USING TOTAL BODY ELECTRICAL CONDUCTIVITY (TOBEC)

In recent years, researchers have shown a strong relationship between body fat and diseases like coronary heart disease, hypertension, and diabetes. One concern, then, is the accurate assessment of body composition. Body fatness is a primary indicator of nutritional status, therefore, a study was conducted to define the accuracy of estimates of body composition, obtained with a total body electrical conductivity (TOBEC) instrument, for the general population. This technology can be used in nutritional surveys in field conditions to assess hard to reach individuals such as home-bound elderly. The TOBEC approach is used to measure lean body mass with body fat calculated as the difference between body weight and lean mass. Males and females ($N=349$) between the ages of 11 and 90 years served as research volunteers. Lean body mass was assessed by underwater weighing procedures, and body conductivity was measured by the TOBEC instrument. The results from this project demonstrated highly significant relationships between the TOBEC conductivity coefficients and lean body mass across all groups. Conductivity coefficients generated by the TOBEC instrument were used to develop prediction equations for lean body mass for the total sample, specific age groups, and obese individuals. These equations gave results similar to those obtained by the underwater weighing procedure for all age groups. The rapidity, noninvasiveness, and accuracy of the TOBEC procedure

sure make it a valuable tool for body composition assessment of the general population.

MEASURING BODY FAT: INTERMETHOD COMPARISONS IN HUMAN SUBJECTS

New methods in body composition research provide new opportunities: construction of multicompartiment models for all components of body weight; definition of the limits of "consistency" assumptions for density, potassium, and water contents in the lean body; and improved accuracy in measuring the major compartments of bone, muscle, and fat. Differences in these body components are important indicators of nutritional status. Measurements were made in 338 normal European-American subjects of body water, underwater weighing, body potassium, and anthropometrics; and the newer methods of dual photon absorptionmetry, bioimpedance analysis, and carbon and nitrogen by *in vivo* neutron activation analysis. Body fat by all methods shows high correlation, with group means ranging from 26 to 35 percent of body weight. Intermethod comparison equations in the form of linear regressions for each sex were formulated to describe the direct inter-relationships among the eight methods. Multiple regression analysis using age, height, weight, and skinfold thickness narrowed the standard error to about +3 percent. Changes in body composition that occur with aging can be accurately monitored using these methods.

EFFECTS OF A SALMON DIET IN HUMANS

Purified fish oils, containing omega-3 fatty acids, when taken as a dietary supplement, decrease blood clotting and influence platelet functions in people and may help to protect against heart disease. Whether the same physiological effects can be obtained from the consumption of fresh fish is unclear. In this study, healthy male volunteers, living in a nutrition unit, consumed a diet containing a pound of salmon per day for 40 days after being on a stabilization diet (no omega-3 fatty acids) for at least 20 days. Blood samples were drawn before and after the salmon diet, and blood clotting values and the fatty acid composition of their plasma, red cells, and platelets were determined. There was no difference in the blood clotting times before and after the salmon diet. There were, however, subtle changes in platelet function and a significant decrease in the platelet counts in the volunteers consuming salmon. The fatty acids in the plasma, red cells, and platelets showed major increases in their omega-3 content. It was found that changes previously reported in people consuming fish oil supplements can be duplicated by consuming fresh fish. Thus, a diet containing fresh fish may provide health benefits.

LONG-TERM FISH OIL SUPPLEMENTATION AND VITAMIN E STATUS OF WOMEN

With the renewed interest in fish oil for the prevention of disease, potentially harmful effects of fish oil products have been overlooked. The effect of fish oil supplementation was investigated in 15 young and 10 older women using 6 capsules/day (concentrated fish oil containing 400 mg omega-3 fatty acids and 1 IU of vitamin E per capsule) for 3 months. It was found that plasma triglyceride level was significantly reduced in both groups with fish oil supplementation. This reduction was concomitant with a significant increase in plasma omega-3 fatty acids. However, the plasma level of lipid peroxides was increased significantly despite the increase in plasma-vitamin-E-triglyceride ratio. This was most pronounced in older women. Lipid peroxides are toxic substances and are oxidative products of omega-3 as well as other polyunsaturated fatty acids (PUFA). The level of these products may increase when the level of vitamin E relative to PUFA decreases or when other oxidative stresses are introduced. The results indicate that long-term intake of fish oil capsules increases lipid peroxide levels in the bodies of both younger and older subjects. The data suggest that it may be necessary to increase vitamin E content of fish oil capsules or, alternatively, the users of fish oil capsules should increase their vitamin E intake.

OMEGA-6 DIETARY FATTY ACID AND PLASMA HDL LIPOPROTEIN

Solution of dietary problems associated with cardiovascular disease (CVD) requires that plasma cholesterol levels be lowered. However, an inherent problem in conducting studies using natural food diets is that when the total amount of fat is reduced, more than one fatty acid class (saturated, monounsaturated, or polyunsaturated) is changed. To avoid this problem, two diets were devised which allowed for the modification of only one fatty acid class. Using this technique, in a study involving 11 healthy middle aged men, reductions in total cholesterol, LDL-cholesterol, and apolipoprotein B-100 and an increase in apolipoprotein A-1, were achieved by increasing only the intake of linoleic acid, an omega-6 polyunsaturated fatty acid.

The most interesting finding was that HDL-cholesterol did not decrease when the higher level of linoleic acid was fed. This is in contrast to findings in previous studies, reporting that high omega-6 PUFA diets lowered plasma HDL-cholesterol. This is important because high levels of omega-6 fatty acids in the diet have been thought to lower serum HDL-cholesterol and in turn increase the risk of coronary heart disease.

FAMILIAL LIPOPROTEIN DISORDERS IN PATIENTS WITH CORONARY DISEASE

Genetic lipid disorders were examined in 102 families of patients with heart disease. Cholesterol lipoprotein levels and apolipoprotein levels were determined on the patient and family members. Half of the patients had a genetic form of lipid disorder, most frequently Lp(a) excess (a genetic condition predisposing to heart disease but not affected by diet), and disorders associated with low HDL cholesterol. It was concluded that these genetic lipoprotein disorders are common in subjects with premature coronary artery disease and such patients, as well as their children, should be checked for such genetic disorders. It is important to be able to discriminate between diet-responsive and nonresponsive lipid disorders in order to provide dietary guidance for prevention of disease.

VITAMIN E AND ENDOTHELIAL PERMEABILITY OF LIPOPROTEINS

Age is strongly correlated to the onset of atherosclerotic lesion formation in humans. This may be associated with an age-related increase in the susceptibility of the vascular endothelium to oxidative injury. Such injury may result in altered endothelial function as a barrier to plasma components, such as cholesterol-rich lipoprotein remnants. To investigate this hypothesis, the relationship between endothelial cell culture age, susceptibility to oxidative injury and protection against this injury by the antioxidant vitamin E on endothelial barrier function (transfer of albumin across endothelium) was examined. An acute 24-h exposure to linoleic acid hydroperoxide resulted in increased albumin transfer at all cell passages tested. Enrichment of cells with vitamin E prior to exposure always protected endothelial cells against oxidized fatty acid-induced cell injury, independent of cell age.

CALCIUM SUPPLEMENTS AND BONE LOSS IN POSTMENOPAUSAL WOMEN

Gradual loss of bone minerals results in the development of spontaneous fractures or osteoporosis in a large proportion of elderly women. Despite extensive investigation, there is no consensus on whether increased calcium intake will reduce bone loss. Results of a pilot study conducted at the Human Nutrition Research Center on Aging suggested that, of women beyond the menopause, those most likely to benefit from calcium are the ones with low dietary intakes of calcium. Therefore, the effect of calcium supplementation was examined in this population, in a large controlled trial. Women within 5 years of menopause (perimenopausal) did not benefit from supplementation with calcium. In contrast, women beyond the perimenopausal period (postmenopausal) with low calcium intakes had reduced bone loss from the spine, hip, and radius when calcium supplements were given. This is the first demonstration in a controlled study that added calcium reduced bone loss from the spine and hip. On the basis of this study, it is recommended that postmenopausal women be urged to increase their calcium intake to approximately 800 mg daily.

EFFECTS OF INCREASED DIETARY CALCIUM AND EXERCISE ON BONE CALCIUM IN POSTMENOPAUSAL WOMEN

Physical activity has been shown to affect the rate of bone loss in postmenopausal women. To date, there have been no studies that have evaluated the interaction between increased levels of physical activity and increased dietary calcium. This study examined the effects of a 1-year (4 days per week, 50 minutes per day) supervised walking program and increased dietary calcium on bone health (measured by examining the bone density of the spine, hip, and radius as well as the total amount of calcium in the body) in postmenopausal women. Four groups of women were followed: (1) women who remained sedentary and did not change their calcium intake, (2) sedentary women who increased their calcium intake by 831 mg/day, (3) walking women with no change in calcium intake, and (4) walking women who increased their calcium intake by 831 mg/day. No interaction between exercise and calcium intake was found. However, the femoral neck (in the hip) increased by 1.9 percent in the women eating the high-calcium diet and decreased by 1.5 percent in those on moderate calcium intake. The exercise caused a 1.2 percent increase in the density of the lower spine while the sedentary women showed a 6 percent decrease. The

data indicate that both increased dietary calcium and exercise have positive but different effects on the bone health of postmenopausal women.

REGULATION OF ACTIVE FORM OF VITAMIN D IN WOMEN

Poor absorption of calcium is thought to contribute to the problems of bone loss and osteoporosis in the elderly. The biologically active form of vitamin D, 1,25-dihydroxyvitamin D, is important because it stimulates the intestinal absorption of calcium. This compound is formed from vitamin D in a reaction that is influenced by the serum concentrations of phosphorus and parathyroid hormone. In this investigation of 275 healthy postmenopausal women, it was found that the serum calcium concentration also directly influences the serum level of 1,25-dihydroxyvitamin D. A low serum calcium increases and a high calcium decreases the level of the active form of vitamin D in the blood. Understanding of the regulation of 1,25-dihydroxyvitamin D is a requisite for developing strategies to enhance calcium absorption in the elderly.

SMOKING AND BONE LOSS AMONG POSTMENOPAUSAL WOMEN

Women who smoke are known to have lower bone density than those who don't smoke. It is generally thought that smoking lowers the peak bone mass that is achieved at around age 30 years. This study was done to determine whether smoking affects the rate of bone loss in healthy postmenopausal women. Thirty-five smokers (who smoked an average of 15 cigarettes per day) and 285 nonsmokers participated in the 2-year study. In all women, the adjusted mean annualized rate of bone loss from the radius was greater among smokers than nonsmokers (-1.38 percent vs. -0.07 percent per year, respectively). Similar trends were observed in the femoral neck, or calsis, and spine among women who were 6 or more years since last menses, (26 smokers and 210 nonsmokers). However, both groups responded equally to calcium supplementation. When compared with nonsmokers, current smokers had accelerated rates of bone loss from the radius and similar trends at the spine, hip, and heel. Thus, smoking, even in amounts of less than one pack per day, has a negative effect on bone health in women after menopause.

ECONOMIC RESEARCH SERVICE (ERS)

Title and purpose statement of each program or activity which affects older Americans

Issues regarding older Americans are approached at the Economic Research Service (ERS) from the perspective of rural development. We actively participate in the Interagency Forum on Aging-Related Statistics at the National Institute of Health. One of our staff is participating in the Forum's Work Group on Older Americans in Rural Areas. The Rural Work Group was formed in March 1991 to prepare an informal briefing "Older Americans in Rural Areas" to be presented to the Senate Aging Committee and staff, as well as members and staff of other Committees.

Brief description of accomplishments

The following reports on the rural elderly have been prepared by our staff in the past year:

Hoppe, Robert A., "The Role of the Elderly's Income in Rural Development," Agriculture and Rural Economy Division, Economic Research Service, U.S. Department of Agriculture. Rural Development Research Report No. 80.

Hoppe, Robert A., "The Elderly's Income and Rural Development: Some Cautions," *Rural Development Perspectives*, Vol. 7, Issue 2, February-May 1991, pp. 27-32.

Rogers, Carolyn C., "Health and Social Characteristics of the Nonmetro Elderly," presented Dec. 4, 1991, at USDA Outlook Conference 1991 and will be published in forthcoming proceedings.

COOPERATIVE EXTENSION SYSTEM

Title and purpose statement of each program or activity which affects older Americans

The Cooperative Extension System (CES), a national educational network, conducts education programs for people of all ages, including the elderly, their children, and their caregivers. This public-funded, nonformal educational network combines the expertise and resources of Federal, State, and local governments. Its mission is to help people—from newborn to the elderly—to improve their lives through an educational process that uses scientific knowledge focused on issues and needs.

As the older population continues to rise in rural areas, Extension has endeavored to increase its programming for and with them. Targeted audiences include older persons, adult children with aging parents, caregivers of home-bound elderly, 4-H members and other youth, opinion leaders, and local decisionmakers.

At all levels, Extension staff are aggressively forging networks to maximize the benefit of programs for this targeted audience. Significant networking has occurred with the Administration on Aging and its State Units on Aging and Area Agencies on Aging, the American Association of Retired Persons (AARP), and the National Council on Aging. Other cooperators include the American and State Associations of Home Economics, the National Rural Health Association, the Health and Human Services Office of Rural Health Policy, the Office of Alcohol and Drug Abuse, and State Association of Homes for the Aging. Linkages have also been made with civic and other community-based organizations, foundations, other colleges in the land-grant institutions, mental health associations, and the National Fire Protection Association.

Brief description of accomplishments

Five of the Cooperative Extension System's seven national initiatives, all of which focus on important societal problems, include older rural residents as clientele. These five are Food Safety and Quality, Revitalizing Rural America, Waste Management, Water Quality, and Youth at Risk. Other ongoing priority program efforts of the System also benefit older clientele. Below are highlights of some of the System's educational programs:

The Senior Series (Coordinated by Missouri)

Dr. Leo Cram, with the University of Missouri Extension Center on Rural Elderly, began the process of having States develop, field test, evaluate, and revise eight educational modules for use with older audiences. The Senior Series and the five regional dissemination workshops have been funded in part by the W.K. Kellogg Foundation, the four Extension Regional Rural Development Centers, and the Farm Foundation.

The workshops, 3 to 3½ days of intensive training on the use of the eight modules, are entitled: Seniors Outreaching Seniors; SOS for Caregivers; Enhancing Self-Care Among the Elderly; Nutrition Education; Intergenerational Relations; Opportunities for Extension to Network; Involving Seniors in Radio and Television; Senior Olympics; and Extension Resources for Use with Seniors. Five hundred Extension staff members and a few State and Area Agency on Aging staff members completed the training this fall. Complete sets of the Senior Series resources are available at the 1862 and 1890 Extension offices for program use by other States and the territories.

Dr. Cram directed the 1991 Extension Summer Gerontology Institute held at the University of Missouri campus. This 5-day intensive workshop met the training and update needs of 30 Extension Service faculty members.

American Association of Retired Persons (AARP) and Extension Co-sponsored Women's Financial Information Program (WFIP)

Extension agents and specialists in 36 States are conducting the Women's Financial Information Program (WFIP) in numerous local communities. The basic curriculum was piloted in several locations by Extension faculty and other cooperators and was funded by AARP. Currently AARP is funding training sessions for the trainers and providing monetary and program resources for local sessions. Reports from Arizona and Colorado typify programs at the sites:

In Arizona 250 people enrolled in the 7-week workshop. Each participant received a workbook that provides guidance for organizing financial affairs, recording accounts, and preparing other important documents. Components of the program are "Organizing Family Records, Analyzing Cash Flow, Setting Financial Goals, Investments and Legal Issues."

In Colorado more than 2,000 women and men participated in the WFIP, co-sponsored with AARP and taught by 18 Extension agents and 4 specialists. Participants increased and learned to apply their financial skills and knowledge. WFIP was also extended to others not able to attend the program, through trained volunteers.

The 270 volunteers, trained to facilitate small groups to increase self-confidence and encourage individual action, contributed more than 11,070 hours valued at \$77,490. They reported several benefits gained—self-confidence in facilitating groups, personal money management skills, contributions to communities, and making a difference with people.

Financial contributions exceeding \$13,000 plus in-kind contributions came from Public Service Co.; American Association of University Women; Department of Design, Merchandising and Consumer Sciences and College of Applied Human Sciences; and Working Women's Fair. Gannett Foundation, Junior League, Area Agency on Aging, United Way, Business and Professional Women, and the Women's Bureau, U.S. Department of Labor are also contributors.

The Governor of Colorado signed a proclamation declaring February 1991 to be Women's Financial Education Month as a result of the team efforts in this program. Initial evaluation (40 responses) revealed that WFIP helped participants to: 100%—discuss finances; 100%—gain financial knowledge; 100%—know where to get more information about financial matters; and 98%—feel more in control of many matters. They also stated these gains: 96%—feel more self-confident about making money decisions; 95%—identify goals; and 90%—seek assistance from financial professionals (bankers, financial planners).

Kentucky

The University of Kentucky Cooperative Extension Committee on Aging is an interdisciplinary group with representatives from Home Economics, 4H/Youth Development, Agriculture, Extension Administration, and the University of Kentucky Sanders-Brown Center on Aging. It was recently formed to coordinate and lead Kentucky's aging-related educational programs. One of the committee's first educational initiatives was a week-long "Challenges of Aging" Conference. Over 100 Cooperative Extension agents and specialists and other professionals in the area of aging attended. One goal was to pilot test the Senior Series, a set of seven guides focusing on creating community-based programs in which senior citizens have meaningful social roles and/or productive volunteer work assignments.

As a result of this conference, single-day Challenges of Aging conferences were held at regional and local levels and many Senior Series programs were initiated at the local level. For example, in Martin County, the Extension Agent for Agriculture worked with the local Senior Citizens Center Director and other organizations to build a greenhouse at the Senior Citizens Center and to establish a nearby garden plot. In Carter County, a telephone reassurance system was launched. In another county, intergenerational relations were strengthened through a Junior-Senior Olympics event that involved 600 young people and seniors. In Jefferson County, a group of students with behavioral disorders developed skills in puppetry and pet therapy, which they in turn used to share with older persons in nursing homes, hospitals, and VA Centers.

Other programs included an intergenerational initiative with Head Start children, a county needs assessment, and newsletters focused on nutrition and caregiving. Other Senior programs were Living Arrangements in Later Life (3,950 attendants); Coping with Caregiving: How to Manage Stress When Caring for Older Relatives (3,200 participants); and Aging Parents: Helping When Health Fails (2,300 attendants).

Maine

The Senior Community Service Employment Program (SCSEP) has operated in Maine (all 6 counties) for 23 years. FY 1991 budget of \$988,400 came from a grant from the National Council on the Aging. This program trains low-income people over age 55 and in good health. Over the 4-year period, 1,200 people have been employed. As a result of job clubs and training experience provided at work sites and in educational settings, 54 individuals obtained unsubsidized placement in FY 1991. (A total of 158 obtained jobs over the 4 years.) All of the participants report an increase in their work capabilities and enhanced self-esteem.

For FY 1991, the Senior Companion Program (SCP) operated in four (previously three) counties within Maine, employing 70 Senior Companion volunteers. Over 400 home-bound elderly receive support services each year. These services save participating families over \$1 million annually, or \$2,750 per family (in-home health care costs a minimum of \$11/hour). Self-esteem of the Senior Companions and the home-bound elderly has improved.

Massachusetts

A Northeast intergenerational initiative is funded in part by the Northeast Rural Development Center. The proposal and the cooperation of the 13 States and DC in Extension's Northeast region were obtained by Dr. Elsie Feterman. Project coordinators write and distribute monthly newsletters for use in each State in the region. A survey has been conducted to determine the status of Intergenerational Programs in the States and a workshop is being planned for sharing of successful programs and resources.

New Jersey

Rutgers University Extension Home Economists piloted the WFIP in cooperation with AARP in two counties. Two hundred and ninety-six women participated in the two seminar series. Thirty-five community organizations provided support. Nineteen financial management resource speakers and 46 small group facilitators provided 1,430 volunteer hours assisting women with financial management training. Participants have reported that the financial management series has improved and enhanced their financial skills.

Five counties provided WFIP to 452 women during fall 1991. Seventy-five community organizations support the seminars for which 41 financial management resource speakers and 76 facilitators provided 2,574 volunteer hours of service. Seven more counties have organized WFIP coalitions and seminar series to be held in spring 1992. WFOP focuses on mid-life and older women, but the New Jersey seminars have attracted women of all ages who want to improve financial management skills.

New York

Cornell University Cooperative Extension home economics agents received inservice training in new developments affecting family caregivers. The instructors—Extension specialists, a New Jersey county agent, and an attorney—covered housing, financial issues, policy and the relationship between family members and nursing home staffs. The training was provided so that county Extension agents can conduct nonformal education programs for clientele.

Oregon

“Mental Health and Aging: A Series of Multimedia Education Workshops” consists of three comprehensive workshops developed by Dr. Vicki Schmall, Oregon State University (OSU) Extension Gerontologist. The workshops address such mental health concerns of later life as loss and grief, depression and suicide, and alcohol problems. Over 2,000 professionals, family support group facilitators and educators, and 15,000 family members and older adults have been through the training.

The Extension staff in Kentucky, Iowa, Kansas, and Pennsylvania are using the resources. Case Reserve Geriatric Program (Ohio) has adopted the programs for statewide training of providers in the aging network and alcoholism counseling fields. The Oregon Senior Peer Counseling programs have adopted the series for statewide use.

The project involved collaboration between the Oregon State University Extension Service; OSU College of Education; Administration on Aging, Health and Human Services (partial funding); Oregon Senior Services Division; Mental Health Division; the Oregon Association of Homes for the Aging; Area Agencies on Aging; and the Office of Alcohol and Drug Abuse.

“Enhancing Selfcare Skills Among the Elderly” is a training manual and program for use with older adults. It addresses nutrition and health concerns in later life. The program helps older people prevent or reduce risk of health problems by recognizing when problems occur, and, by knowing what to do, and when to seek professional help.

Pennsylvania

The Volunteer Information Provider Program (VIPP) begun 4 years ago continues to meet the needs of caregivers. In six counties, 41 additional volunteers received the 20 hours of VIPP training. Six volunteers worked with 32 individual caregivers and made group presentations that reached 102 people.

South Dakota

Extension staff in South Dakota taught about the aging process, health promotion, economics and care giving. They trained nursing home staff to understand sensory changes, and to recognize myths and misconceptions about growing old. Three county home economists taught classes on Alzheimers for support groups. Extension staff provided information on economic decisions including nursing home insurance to 312 people in five locations.

An Extension newsletter for family caregivers continues for a second year, going to 1,086 homes. Mailings were funded by the South Dakota Office of Adult Services and Aging. South Dakota State University Extension staff network with the Office of Adult Services and Aging, Food and Drug Administration, senior nutrition sites, senior citizen centers, Extension Homemakers, and support groups.

Virginia

The Volunteer Information Provider Program (VIPP) has been conducted in 45 counties; 336 volunteers who received the training worked one on one with 811 caregivers of the elderly. Extension specialists prepared a quarterly information column, "Aged Wisdom," for publication in newsletters of the Area Agencies on Aging, which reached 283,000 subscribers. The AARP National Health Resource Center receives a copy and Oregon State University, Texas A&M University, and Pennsylvania State University Extension specialists use the column.

During the next 4 years, Cooperative Extension in Virginia will be providing leadership for a statewide collaborative initiative on adult day care in rural and underserved areas of the state. State agencies involved are Department for the Aging and Department of Social and Virginia Association of Area Agencies on Aging. They collaborate with Virginia Cooperative Extension and the Center for Gerontology, at Virginia Polytechnic Institute and State University, to achieve two objectives. Their first is to produce a technical assistance manual that will help community groups and task forces overcome the logistics of planning and developing adult day services. The second is to form a technical assistance team for immediate assistance to communities while developing these services.

Electronic Technology

For many years PENpages has been an information service supported by host computers at Pennsylvania State University Park Campus. PENpages is also the home of MAPP—The Family and Economic Well-Being National Database. MAPP can be accessed by computer, modem, and communications software. The only charges are the long-distance rates associated with the telephone call. The database is available toll-free through the Internet communications network.

From January 1, 1991, to October 31, 1991, the 149 documents related to older citizens and caregivers of interest to professionals in the field of aging were accessed 2,076 times. In early summer, the Senior Series became available through PENpages, and more aging-related documents are being added.

FARMERS HOME ADMINISTRATION

Title and purpose statement of each program or activity which affects older Americans

Currently FmHA has two programs that directly affect older Americans:

Federal Domestic Assistance (FCA) catalog number 10.315 Rural Rental Housing (RRH) Loans empower the agency authorized under the Housing Act of 1949 as amended, Section 515 and 521, Public Law 89-117, 42 U.S.C. 1485, 1490a to make RRH loans. The objectives of this program are to provide and construct rental and cooperative housing and related facilities suited for dependent living for rural residents. Occupants must be low-to-moderate income families, elderly (62 years or older) or disabled.

During fiscal year 1990, OBPA records show \$571,903,000 was obligated to this program, and fiscal year 1991, \$571,334,000. There is an estimated \$573,900,000 allocated for fiscal year 1992 for the 515 program.

The second program, FDA 10.417 Very Low-Income Housing Repair Loans and Grants (Section 504, Rural Housing Loans and Grants) is also authorized under the Housing act of 1949, its particular title is Title V, Section 504, as amended, Public Law 89-117, 89-754, and 92-310, 42 U.S.C. 1474. The objectives are to give very low-income rural homeowners an opportunity to make essential repairs to their homes to make them safe and to remove health hazards to the family or to the community. Applicants must own and occupy a home in a rural area and be without sufficient income to qualify for a section 502 loan under the FmHA regular housing program. To be a grant recipient, the applicant must be 62 years of age.

Funds allocated and expended under this program were: (Loans) fiscal year 1990—\$11,558-404; fiscal year 1991 \$11,195,590; (Grants) fiscal year 1990—\$12,642,930; and fiscal year 1991 \$12,743,040.

Brief description of accomplishments

In fiscal year 1991, 375 elderly projects were funded under the Rural Rental Housing Loan Program.

Under the Very Low Income Housing Repair Loans and Grants, 2,996 loans and 3,664 grants were made in fiscal year 1990. In fiscal year 1991, 2,951 loans and 3,695 grants were made.

FOOD AND NUTRITION SERVICE (FNS)

Title and purpose statement of each program or activity which affects older Americans and brief description of accomplishments

The Food Stamp Program provides monthly benefits to help low-income families and individuals purchase a more nutritious diet. In fiscal year 1990, \$14.2 billion in food stamps were provided to a monthly average of 19.9 million persons.

Households with elderly members accounted for approximately 20 percent of the total food stamp caseload in fiscal year 1989. However, since these households were smaller on average and had relatively higher net income, they received only 7.9 percent of all benefits issued.

The Food and Nutrition Service (FNS) continues to work closely with the Social Security Administration in order to meet the legislative objectives of joint application processing for Supplemental Security Income households.

FNS is also participating in the Supplemental Security Income Modernization Project. This project was initiated by the Commissioner of the Social Security Administration in order to review and study the Supplemental Security Income Program. As part of the process, hearings are being conducted in different parts of the country to obtain information about the program.

In fiscal year 1991, FNS worked closely with the American Association of Retired Persons (AARP) in order to assist the Association with 10 Public Benefits Outreach Projects. The projects focused outreach efforts on Food Stamps, Supplemental Security Income and Medicaid simultaneously. The following outreach project sites were selected by AARP: Oakland, CA; Atlanta, GA; Wichita, KS; Escanaba, MI; Las Vegas, NV; Concord, NH; Buffalo, NY; Durham, NC; Hillsboro, OR; and Huntington, WV. Food and Nutrition Service staff reviewed AARP's Food Stamp Training Manual for outreach volunteers, provided Food and Nutrition Service informational materials and posters in English and Spanish, provided speakers for the majority of the kickoff events, provided technical assistance, sent letters of support to the project sites, met with the firm evaluating the project, and participated in the September Public Benefits Outreach Conference. The national conference was sponsored by AARP with support from The Commonwealth Fund Commission On Elderly People Living Alone. The Conference provided a forum to discuss methods of reaching those who are potentially eligible for government assistance.

FNS plans to continue to provide technical assistance to AARP as the outreach project sites are evaluated and will work with AARP on any future endeavors.

The Food Distribution Program for Charitable Institutions and Summer Camps provides commodities to nonprofit charitable institutions serving the needy. Eligible charitable institutions include nonpenal, noneducational, nonprofit organizations such as homes for the elderly, congregate meals programs, hospitals and soup kitchens.

It is thought that a large proportion of the beneficiaries of this program are elderly, but accurate estimates are not available.

In total, about \$103.6 million in commodities were distributed through this program.

The Commodity Supplemental Food Program provides supplemental foods, in the form of commodities, and nutrition education to infants and children up to age 6, pregnant, postpartum or breastfeeding women, and elderly 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 exceed those needed to serve women, infants and children. In fiscal year 1990, \$18 million was spent on the elderly component.

About 17 percent of total program spending provides supplemental food to approximately 107,000 elderly participants a month. Older Americans are served by 12 of the 20 State agencies.

The Food Distribution Program on Indian Reservations 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 \$23 million of total costs went to households with at least one elderly person. (This figure was estimated using a 1990 study that found about 39 percent of FDIPIR households had at least one elderly individual.)

This program serves approximately 54,000 households with elderly participants per month.

The Child and Adult Care Food Program provides Federal funds to initiate, maintain, and expand nonprofit food service for children and elderly or impaired adults

in nonresidential institutions which 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 of meals and supplements served to person 60 years or older and to functionally impaired adults. 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 eligible adults. In fiscal year 1990, \$7.9 million was spent on adult day care component.

The adult day care component of CACFP served approximately 8 million meals and supplements to about 45,000 participants a day.

A study of adult day care is currently underway in the Office of Analysis and Evaluation. The objectives of this study are to: (1) describe the characteristics of the adults and the adult day care centers participating in the adult day care component of CACFP; (2) compare participating centers and adults to centers and adults not participating in the Program; (3) determine participants' dietary intakes; and (4) project potential future Program growth.

The Emergency Food Assistance Program (TEFAP) provides nutritional assistance in the form of commodities to emergency feeding organizations for distribution to low-income households for household consumption or for use in soup kitchens.

Approximately \$10 million in commodities were distributed to households headed by the elderly. (This figure is estimated using a 1986 survey indicating that about 38 percent of TEFAP households have members 60 years of age or older.)

About 38 percent of the households receiving commodities under this program had at least one elderly individual.

FOOD SAFETY AND INSPECTION SERVICE (FSIS)

Title and purpose statement of each program or activity which affects older Americans and a brief description of accomplishments

FSIS is continuing a consumer education campaign targeted to older Americans, one of several groups of people who face special risks from foodborne illness. The goal is to reduce the incidence of foodborne illness due to consumer mishandling of food. Foodborne illness can lead to serious health problems and even death for a person who is chronically ill or has a weakened immune system. The elderly, with more than 35 million people in their ranks, are the largest group at risk and are increasing in number.

The Spring and Holiday issues of FSIS' "Food News for Consumers" magazine contained articles detailing how foodborne illness affects those at-risk and how to prevent it. Reprints of these articles were made available to organizations representing or providing services to the elderly. A press release and video news release were distributed to media outlets outlining the risks for foodborne illness in traditional holiday foods. These releases contained special food handling instructions to prevent illness from striking older Americans attending the family holiday meal.

Additional materials were distributed at conventions such as the annual meeting of the National Council on Aging and the Conference of Patient Education sponsored by the American Academy of Family Physicians. FSIS ran a workshop at the National Association of Nutrition Service Providers Convention which provided tips on safe food handling to members who staff Meals on Wheels feeding programs for the elderly.

FSIS surveyed USDA's County Extension Service Agents to identify what types of materials they could use in their outreach efforts to the elderly. FSIS will develop appropriate materials based on the survey results during 1992.

FOREST SERVICE

Title and purpose statement of each program or activity which affects older Americans and a brief description of accomplishments

The Department of Agriculture, Forest Service, in cooperation with the Department of Labor, sponsors the Senior Community Service Employment Program (SCSEP), which is authorized by Title V of the Older Americans Act, as amended. The SCSEP has three fundamental purposes: (1) part-time income for disadvantaged persons aged 55 and over; (2) training and transition of participants to the private/public sector labor markets; and (3) community services to the general public. This program employs economically disadvantaged persons age 55 and older in 38 States, the District of Columbia, and Puerto Rico. The SCSEP seeks to improve the welfare

of underprivileged, low-income elderly, and to foster a renewed sense of self-worth and community involvement among the rural elderly.

Program participants are involved in projects conducted by the Forest Service such as construction, rehabilitation, maintenance, and natural resource improvement work. Participants receive at least the minimum wage to supplement opportunity to have participants regain a sense of involvement with the mainstream of life through meaningful work. Additionally, valuable conservation projects are completed on National Forest lands.

The Service's Interagency Agreement for July 1, 1990 to June 30, 1991, provided \$23.8 million which employed an estimated 5,700 seniors; 22 percent were minorities, and 38 percent were women. Fifteen percent of the participants were later placed in nonsubsidized jobs. The Government reaped a return of \$1.58 for each dollar invested in this program.

The volunteer in the National Forests Program offers individuals from all walks of life the opportunity to donate their services to help manage the nation's natural resources. This program continues to grow in popularity as people realize how they can personally help carry out natural resource programs. Volunteers assist in almost all Forest Service programs or activities except law enforcement. They may choose to work in an office at a reception desk, operate a computer terminal, or conduct natural history walks and auto tours. Volunteers may also be involved in outdoor work such as building trails, maintaining campgrounds, improving wildlife habitat, and serving as a host at a campground.

During fiscal year 1990, 11,526 persons aged 55 and above volunteered their services in the National Forest.

ITEM 2. THE DEPARTMENT OF COMMERCE

DECEMBER 13, 1991.

DEAR MR. CHAIRMAN: Thank you for your letter regarding the Department of Commerce programs pertaining to the older Americans.

We are enclosing our report for 1991 for inclusion in *Developments in Aging*, Volume II. The report includes programs relevant to the older population.

If you need further information, please have a member of your staff call Mr. Paul Powell, Bureau of the Census, Office of Congressional Affairs, on (301) 763-2446.

Sincerely,

ROBERT A. MOSBACHER.

Enclosure.

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OTHER REPORTS, PAPERS, DATA BASES, AND CONTINUING WORK

I. THE FEDERAL INTERAGENCY FORUM ON AGING-RELATED STATISTICS

The Census Bureau is one of the lead agencies in The Federal Interagency Forum on Aging-Related Statistics (The Forum), a first-of-its-kind effort. The Forum encourages cooperation among Federal agencies in the development, collection, analysis, and dissemination of data pertaining to the older population. Through cooperation

and coordinated approaches, The Forum extends the use of limited resources among agencies through joint problem solving, identification of data gaps, and improvement of the statistical information bases on the older population that are used to set the priorities of the work of individual agencies. The participants are appointed by the directors of the agencies and have broad policymaking authority within the agency. Senior subject-matter specialists from the agencies are also involved in the activities of The Forum. The Forum was cochaired in 1991 by Barbara Everitt Bryant, Director, Bureau of the Census; Manning Feinleib, Director, National Center for Health Statistics; and T. Franklin Williams and Gene D. Cohen, Directors, National Institute on Aging.

At the initial meeting of The Forum, held October 24, 1986, it was agreed that The Forum would work on the following activities: (1) identify data gaps, potential research topics, and inconsistencies among agencies in the collection and presentation of data related to the older population; (2) create opportunities for joint research and publications among agencies; (3) improve access to data on the older population; (4) identify statistical and methodological problems in the collection of data on the older population and investigate questions of data quality; and (5) work with other countries to promote consistency in definitions and presentation of data on the older population.

Three standing committees were established to carry out specific activities: (1) Data Needs and Analytic Issues, chaired by Joan Van Nostrand (National Center for Health Statistics); (2) Methodological Issues, chaired by Richard Suzman (National Institute on Aging); and (3) Data Presentation and Dissemination, chaired by Cynthia Taeuber (Bureau of the Census).

The work of The Forum facilitates the exchange of information about needs at the time new data are being developed or changes that are being made in existing data systems. It also works to promote communication between data producers and policymakers.

As part of The Forum's work to improve access to data on the older population, the Census Bureau publishes an information bulletin titled *Data Base News in Aging*, which brings news of recent developments in data bases of interest to researchers and others in the field of aging. All Federal agencies are invited to contribute to the bulletin, which is issued periodically.

The Census Bureau has also published a report of the Income Working Group of the Federal Interagency Forum on Aging-Related Statistics titled *Income Data for the Elderly: Guidelines*, which recommends ways in which data-collecting agencies can improve the comparability, quality, and usefulness of the income data collected across surveys; a *Forum Telephone Contact List* of major agencies and staff who work on specific aspects of aging-related statistics; the *Inventory of Data on the Oldest Old*, which is a reference document of Federal data bases on the oldest old population; and will soon publish the *1989-1990 Report of the Forum*, which reviews the activities of The Forum and its member agencies. Various sections of this report summarize Forum work and accomplishments, cooperative efforts of members, publications by member agencies, and activities planned for 1991.

The National Center for Health Statistics, a participating Federal agency of The Forum on Aging-Related Statistics, has published a report from the Committee on Estimates of Activities of Daily Living in National Surveys titled *Measuring the Activities of Daily Living Among the Elderly: A Guide to National Surveys*. This report focuses on the activities of daily living and provides a guide to policymakers and researchers on the national surveys that measure activities of daily living and on the issues that must be addressed in using data from these surveys.

The Forum on Aging-Related Statistics has established working groups on subjects of current interest. The Working Group on Disability is considering how to measure disability, with an emphasis on cognitive disability. The Working Group on Data on Minority Aging is making an inventory of Federal and other large data sets to identify the extent to which data are available on minority groups in the older population. The Working Group on Older Americans in Rural Areas is preparing a briefing for Congressional staff on whether available data support common beliefs about the rural elderly.

II. PROJECTS BETWEEN THE CENSUS BUREAU AND THE ADMINISTRATION ON AGING

From the 1990 census, the Census Bureau plans to produce special tabulations particularly useful to local area agencies on aging for administering programs under the Older Americans Act. The Census Bureau also plans to produce a 1990 census subject report, *The Older Population in the United States*, with information published in printed form at the national level, and in computer files (on magnetic tapes or compact disks) for States. The Census Bureau will also prepare a 1990

census public-use microdata file with individual questionnaire information (less identifying information) for 5 percent of persons aged 60 and over and members of their households.

A report titled "Guide to 1980 Census Data on Elderly" was published in 1986. This guide explains how to locate census data on the older population. The report reviews census products, services, and explains how to obtain them. The report has table outlines from the census publications and summary tape files to show the specific form of data available about the older population.

III. PROJECTS BETWEEN THE CENSUS BUREAU AND THE NATIONAL INSTITUTE ON AGING

A. The Census Bureau is preparing a report, "65 Plus in the U.S.A.," a chartbook and analysis of demographic, social, and economic trends among the older population. This report will use 1990 census data and expands on "Diversity: the Dramatic Reality" by Cynthia M. Taeuber, Chapter one of *Diversity in Aging* Scott A. Bass, Elizabeth A. Kutza, Fernando M. Torres-Gil, eds., (Glenview, IL, Scott, Foresman and Co., 1990).

B. The Census Bureau is preparing a series of "Profiles of the Elderly Population," 2- or 4-page briefs on demographic, social, and economic trends among the elderly. Topics will include demographic changes during the 1980's, racial and ethnic characteristics, international comparisons of older populations, and characteristics of the centenarian population.

C. The Census Bureau prepared a paper, "The 1990 Census and the Older Population: Data for Researchers, Planners, and Practitioners" by Cynthia M. Taeuber and Arnold A. Goldstein. The paper summarizes availability of 1990 census data on topics of interest to researchers on the older population.

D. The Census Bureau prepared special tabulations from the 1980 census for the National Institute on Aging. These tabulations include selected tables from Summary Tape File 5 retabulated with 5-year age groups from 60 years to 85 years and over. These tabulations also include other selected tabulations from the 1980 census. The University of Michigan archives these tabulations (Barbara Lamar, 313-763-5010).

E. The Census Bureau developed an international data base on the older population. The University of Michigan archives this data base (Barbara Lamar, 313-763-5010).

F. The Census Bureau established a joint Visiting Scholar Program to allow scholars to do research in residence at the Census Bureau.

G. The Census Bureau prepared a study of the quality of census data on the elderly which includes an evaluation of coverage, age misreporting, estimates, and projections of centenarians, and so forth.

H. The Census Bureau prepared a file from the Survey of Income and Program Participation (SIPP) on the health, wealth, and economic status of the older population. The SIPP file is completed and is archived at the University of Michigan (Barbara Lamar, 313-763-5010).

I. Programming has started on the annual report on the older population, *Aging America*, using Current Population Survey data. Data will be provided for persons aged 65-74, 75-84, and 85 and over. Most data will be cross-tabulated by sex, race, and Hispanic origin. Some data will be produced in confidence intervals because of small sample sizes for the aged.

J. The Census Bureau provided The Forum with special tabulations on poverty of nonmetropolitan elderly (from 1989 Current Population Survey).

K. A paper titled "Minority Elderly: An Overview of Demographic Characteristics" was prepared by Cynthia M. Taeuber and Denise I. Smith of the Census Bureau. The paper focuses on increases in the minority elderly population, those 65 years and over, and the differences among age, race, and ethnic groups within the older population. Some of the characteristics of the minority elderly population discussed are marital status, living arrangements, median income, and poverty status.

L. "A Demographic Portrait of America's Oldest Old" was prepared by Cynthia M. Taeuber, Bureau of the Census, and Ira Rosenwaike, Graduate School of Social Work, University of Pennsylvania, for a chapter in a book. This chapter looks at the rapid growth of the oldest old population, those 85 years and over and the reasons for that growth. This chapter also: (1) compares the oldest old's demographic, social, and economic characteristics with those of the younger old; (2) describes the characteristics of the centenarian population; (3) examines the quality of census data on the oldest old; and (4) discusses the implications of the growth and characteristics of this unique and important group.

M. The Census Bureau reprogrammed the regularly published tabulations of the Current Population Survey to include data for the population "65 to 74 years" and

"75 years and over" in annual reports (see especially P-20, Nos. 450 and 447, P-60, Nos. 175 and 174).

IV. INTERNATIONAL RESEARCH ON AGING

A. Studies from the International Data Base on Aging:

1. "Demographic Dimension of Population Aging in Developing Countries," submitted as a chapter for the forthcoming *Journal of Human Biology*. Kevin Kinsella of the Census Bureau and Richard Suzman of the National Institute on Aging are the authors of this chapter. In this chapter several demographic aspects of population aging in developing countries are considered—the older old, median population age; life expectancy and mortality; functional status and disability and sex differences. While the demographic impact of the population aging is becoming better appreciated, the descriptive epidemiology of age-related changes in health and physical functioning in developing countries is still at an early stage.

2. A paper titled "Population Dynamics of the United States and the Soviet Union" was prepared by Barbara Boyle Torrey and W. Ward Kingkade of the Census Bureau for the United Nations Seminar on Demographic and Economic Consequences and Implications of Changing Population Age Structures in Ottawa, September 1990. This paper was also published in the *Science Journal*, March 30, 1990, Volume 247.

3. A paper titled "Changes in Life Expectancy—1900 to 1990" was prepared by Kevin Kinsella of the Census Bureau for presentation at an International Conference on Aging: Nutrition and the Quality of Life in Marbella, Spain. The paper summarizes levels of and changes in life expectancy at birth and at older ages in industrialized countries during the 20th century. Trends in mortality and morbidity are summarized in the context of the historic epidemiological transition in the nature of disease from infectious to chronic. Cause-specific and active/inactive decompositions of life expectancy are examined, as are initial attempts to correlate life expectancy with physical attributes that may reflect differential nutritional status.

4. "Demography of Older Populations in Developed Countries," submitted as a chapter for the forthcoming Oxford Textbook of Geriatric Medicine. Richard Suzman of the National Institute on Aging, Kevin Kinsella of the Census Bureau, and George C. Myers of Duke University are the authors of this chapter. The chapter explores differences and similarities among the aging process and elderly populations in 34 industrialized nations. The chapter reviews past and projected trajectories of growth of older populations, socioeconomic characteristics, and current and expected health status.

5. "The Paradox of the Oldest Old in the United States: An International Comparison," submitted as a chapter in a future Oxford University Press publication. Barbara Boyle Torrey and Kevin Kinsella of the Bureau of the Census and George C. Myers of Duke University are the authors of this paper. The paper focuses on three topics related to the oldest old (80+) in eight countries. The topics discussed are demographic trends, marital status and living arrangements, and income. The paper shows cross-country comparisons and trend data on the above topics for the period 1985 to 2025.

6. A paper titled "Suicide at Older Ages—An International Enigma," was prepared by Kevin Kinsella of the Census Bureau for presentation at the Gerontological Society of America meeting, November 1991. This paper examines the suicide rates in the United States as compared with those in 20 industrialized countries using World Health Organization data files from 1965 through 1989.

7. The Center for International Research completed updates of the original 42 countries in the International Data Base on Aging, with special emphasis given to the incorporation of recent data on marital status.

8. A program version of the International Data Base on Aging was created for use on microcomputers and is being distributed by the Interuniversity Consortium for Political and Social Research.

9. A wall chart on Global Aging was prepared by The Center for International Research for wide distribution, based largely on information from the International Data Base on Aging. The multicolored chart includes demographic and social statistics for 100 countries and also features tables and graphs that highlight important research topics in the field of aging.

10. The Center for International Research is updating the 1987 publication *An Aging World*. The new version, which will be available in 1992, will reassess demographic and health trends on the basis of statistics from recent population censuses and surveys. This report also will emphasize a number of topics that

have generated increased research and general interest during the last 5 years: the oldest old; aging in Eastern Europe; healthy and disability-free life expectancy; and living arrangements (including institutionalization).

11. The Center for International Research is preparing a report that will focus specifically on population aging and health trends in Eastern Europe. Countries of this region are among the "oldest" in the world and have age structure and mortality characteristics that are unusual vis-a-vis other developed nations in Western Europe and North America. Data on the rapidly aging population of the former Soviet Union will be included. This report will be preceded by two or more published "briefs" on selected countries, which are designed to provide an overview of salient trends that will be more fully explored in the larger report.

12. The Census Bureau published the first six of a series of 20 statistical briefs: "Aging Trends-Barbados," "Aging Trends-Kenya," "Aging Trends-Thailand," "Aging Trends-Guatemala," "Aging Trends-Jamaica," and "Aging Trends-Zimbabwe." All were prepared by the Center for International Research of the Census Bureau. These profiles include a contrast of current and future numbers and proportion of older populations and comparative data for other nations in the immediate geographical region.

13. A paper titled "Living Arrangements of the Elderly and Social Policy: A Cross-National Perspective" was prepared by Kevin Kinsella of the Census Bureau. The paper examines family and household structure, changes over time, and potential implications for social support and expenditures.

14. A paper titled "A Comparative Study of the Economics of the Aged," was presented at the Conference on Aged Populations and the Gray Revolution in Louvain, Belgium. Barbara Boyle Torrey and Kevin Kinsella of the Bureau of the Census and Timothy Smeeding of Vanderbilt University are the authors of this paper. The paper presents estimates of how social insurance programs for the aged have grown as a percentage of gross domestic product in several countries partly as a result of lowering retirement age and an increase in real benefits. It then discusses how the labor force participation of the aged in these countries has uniformly declined. Finally, it examines what contribution the Social Security benefit makes to the total income of the aged at present and how the average income of the aged compares to the average national income in each country.

15. *Aging in the Third World* has been published in International Population Reports, Series P-95, No. 79.

16. *An Aging World* has been published in International Population Reports, Series P-95, No. 78.

B. The Census Bureau completed a contract with Meyer Zitter, a consultant in demographics, to work with other industrialized countries to produce internationally-comparable data on the older population from the 1990 round of censuses. A report titled "Comparative International Statistics available on the Older Population" was prepared by Meyer Zitter and is available. The report focuses on data available from the 1980 round of censuses and what subjects will be available from the 1990 round of censuses. The countries also sent 1980 census tabulations that are somewhat comparable. This report will make it possible to recommend tabulations for 1990 that countries may wish to produce to allow international comparability.

V. OTHER

A. The Census Bureau prepared text on the older populations for inclusion in the Census Bureau's publication, *Population Profile of the United States: 1991*, Series P-23, No. 173.

B. The Census Bureau prepared a paper on "Emerging Data Needs for the Elderly Population in the 21st Century" for public discussion of the census of 2000.

ITEM 3. DEPARTMENT OF DEFENSE

DECEMBER 16, 1991.

Hon. DAVID PRYOR,
Chairman, Special Committee on Aging,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Department of Defense is pleased to have the opportunity to provide information on our activities on behalf of older Americans.

We have prepared a compendium of activities undertaken in the Offices of the Secretary of Defense (OSD), the Military Departments and five of the Defense Agencies. These reports demonstrate a renewed and growing awareness of the needs of

our military and civilian work force and their families. The response to these needs is gratifying and portend the future of Elder Care in the Department.

Sincerely,

SARA B. RATCLIFF,
*Deputy Assistant Secretary of Defense
 (Civilian Personnel Policy and Equal Opportunity).*

Attachment: As stated.

DEPARTMENT OF DEFENSE—1992 DEVELOPMENTS IN AGING REPORT

The Office of Personnel Support, Families and Education in the Office of the Secretary of Defense has been researching the issue of support for the elderly and support for family members providing care for these aging persons. It has come to our attention through increased publicity and through known demographic trends that the elderly population is rapidly increasing. This illustrated expansion in America's elderly population presents a need for increased education and information on elder care issues. The Department of Defense (DOD) recognizes this trend, and, therefore, has been making great progress in creating an elder care support program.

For example, DoD recently established an "Elder Care Task Force" comprised of representatives from the Departments of the Army, Navy, and Air Force, as well as representatives from the Civilian Personnel office, the Chaplains Board, the Federal Women's Program Board, and the Office of the Secretary of Defense. This task force has been meeting to discuss ways to provide support for the elderly and their caregivers.

Initial plans for the DoD Elder Care Program are to provide ongoing educational information to the military and civilian populations and their families. This information would cover such issues as long-term care insurance, Medicare, Medicaid, nursing homes, adult day care and other issues. DoD will implement a "Caregiver Support System" which will make the task of providing care for an elderly relative or friend more manageable by providing needed resources and support programs. There will also be an ongoing effort to train family center personnel, medical personnel, chaplains, and others to form caregiver networks, support groups, informational seminars and other helpful mechanisms to make the responsibility of being a caregiver more manageable. Also, the effort to promote military community awareness will increase and continue by publishing elder care information in family support center publications, and other military and DoD publications.

The Department of Defense continues to maintain its awareness of emerging employee assistance trends and needs and will adopt the most appropriate, comprehensive DoD Elder Care Plan needed by both the military and civilian population and their families.

WASHINGTON HEADQUARTERS SERVICES,
 PERSONNEL AND SECURITY,
November 25, 1991.

In response to your memo of October 15, 1991, requesting input for the annual Developments in Aging Report, Volume II, the following information is submitted.

Principally, the Washington Headquarters Services (WHS) Personnel and Security Directorate does not have an established program for elderly care. Because of the few requests for elderly care assistance, requests are handled as they arise. However, WHS military employees, both active duty and retirees, receive support from their parent military organizations. This is also true for military dependents employed by WHS.

To the maximum extent possible, information and limited assistance for elderly care is provided upon request. Examples include: (1) Pre-retirement seminars, where employees receive information on agencies and organizations sensitive to the needs of the aging; (2) WAE (When Actually Employed) Program, which allows employees the flexibility to tailor their work schedule; and (3) Permanent Part-time, another program which provides flexibility in work-hours, which can be used by employees to provide elder care.

As DoD policy is formulated and programs are approved for aging and elderly care assistance, this office will assess its needs and adopt those programs most beneficial to its serviced population. My staff point of contact for this action is Mr. Tom Tucker, ext. 36309/36320.

A. COPENFRUS
(for Leon Kniaz, Director).

DEPARTMENT OF THE ARMY

Although the Department of the Army (DA) does not have an established program of support groups for elder dependents of active duty members and elder retirees and their family members, the Army does seek to help in several ways. To the maximum extent possible, installation Army Community Services maintain a listing of elder and other support groups available in the local civilian community. Individuals who seek these support groups are then appropriately referred.

The DA has a viable Retirement Service Program as outlined in AR 608-25 (Tab A).^{*} This program is administered by installation Retirement Services Officers (RSO) who are either Federal civil service employees or active duty personnel. Installations also have Installation Retiree Councils assisting the RSO and the commander in providing information and support to Army retirees. Installations publish retiree newsletters and conduct annual Retiree Appreciation Days which are designed to provide information updates, cursory medical checks, and opportunities for continual bonding of the retired community with the active duty community.

The U.S. Soldiers' and Airman's Home (USSAH) provides a place of residence for disabled and aged retirees under title 24 and AR 90-2 Tab B).^{*} The USSAH provides a full range of support for retirees who reside at the home.

The DA Widowed Support Groups, established at installations under the guidelines in DA Pamphlet 608-46 (Tab C),^{*} are operated for the mutual support of all those widowed by either an active duty or a retiree death. It is open to all regardless of age.

There is also an installation volunteer Family Support Group Program as outlined in DA Pamphlet 608-47 (Tab D).^{*} This program does not target the elderly, but they are welcomed into the program, either as family members or as volunteers to help operate the program. Installation Army National Guard units and Army Reserve Family Support Groups during Operations Desert Shield/Storm demonstrated their value, for they truly functioned in an outstanding manner.

Equal employment opportunity complaints are processed on the basis of age in accordance with Equal Employment Opportunity Commission requirements. The Army is also participating in the Department of Defense Elder Care Task Force which will review employee needs and policy developments in the area of caring for elderly parents. The DoD program will be implemented within existing resources, utilizing existing DoD structures.

ROBERT M. EMMERICHS,
Deputy Assistant Secretary,

(Military Personnel Management and Equal Opportunity Policy).

Attachments.

DEPARTMENT OF THE NAVY

The Department of the Navy makes extensive use of flexible work schedules and part-time employment in its civilian workforce. Both of these options are available for aging citizens who may have already retired from one career, or those who may never have worked before and may be seeking only employment with limited work hours or with flexible schedules. Job-sharing is another option available to those interested in employment. While only being tested in limited areas at this time, the flexible workplace program may prove to be of interest to aging citizens.

Recognizing the value of their experience and expertise, we continue to reemploy Federal annuitants and retired military members in various occupations, both in CONUS and overseas.

We have been working closely with the National Association of Retired Federal Employees (NARFE) in Pensacola, FL and Vallejo, CA (Mare Island Naval Shipyard), in support of their centers to provide counseling and advisory services to retired Federal employees. We have recently publicized their program to other activities and encouraged additional cooperative efforts. Such joint efforts will provide an invaluable resource for placement assistance to individuals choosing retirement or faced with separation as a result of downsizing.

Aging Americans also continue to be covered under the Department's Equal Employment Opportunity Program which strives for a diverse workforce.

DOROTHY M. MELETZKE,
Deputy Assistant Secretary of the Navy,
(Civilian Personnel Policy/Equal Employment Opportunity).

^{*} Pamphlets are held in Committee files.

DEPARTMENT OF THE AIR FORCE

Our query of the field reveals a variety of Air Force programs for military and civilian retirees.

Medical programs center around promoting healthy lifestyles and providing medical, dental and pharmaceutical services on a space-available basis. Specific programs include: (1) USAF Health Promotion Program invites representative from each base's Retiree Affairs Office to help market wellness initiatives to retirees and their families, (2) AF Medical Services is gathering baseline data on retiree health in support of DOD's Year 2000 Health Objectives for the Nation, and (3) other routine health promotion activities specifically targeted to older beneficiaries and their families.

Air Force Personnel programs include: (1) Civilian Personnel's establishment of retiree service centers in cooperation with the National Association of Retired Federal Employees, (2) retiree councils to enable retired military members to maintain contact with the Air Force, (3) a social activities group at Ramstein Family Support Center, Ramstein AB, Germany, and (4) information programs for those who are caring for aging parents at Hanscom AFB, MA.

We are including additional information on each program area that may prove helpful for your report.*

WILLIAM G. NORTON,
Deputy Assistant Secretary of the Air Force
(Force Support and Personnel)

DEFENSE LOGISTICS AGENCY

DLA's trial and gradual retirement options are the only programs intended exclusively for older employees. These programs are designed to facilitate adjustment to retirement and to relieve some of its accompanying anxiety. Trial retirement permits an employee eligible for optional retirement to return as a reemployed annuitant within 1 year after separation; gradual retirement provides a part-time work plan for the employee who is eligible for optional retirement but not ready for full-time retirement. Six individuals participated in these programs during FY 91, and a total of 97 reemployed annuitants were in the workforce.

Other programs available to all eligible employees, but of particular significance to older people, are comprehensive health testing and part-time employment. It is also Agency policy to establish physical requirements for positions at the minimum level compatible with safe and productive work performance.

Allegations of age discrimination are handled through regular EEO channels and local resolution is encouraged. Seventy-nine formal complaints filed during the reporting period included an allegation of age discrimination. Age discrimination was not a factor, however, in any of the three cases that were settled with a finding of discriminatory bias.

Thank you for the opportunity to participate in this effort.

A. C. RESSLER,
Deputy Staff Director, Civilian Personnel

DEFENSE MAPPING AGENCY

1. During the past fiscal year, several initiatives specifically beneficial to the older employee were made available at Headquarters, Defense Mapping Agency (DMA):

a. Dr. Billick, of Georgetown University, presented a lecture on Elder Care to approximately 55 employees.

b. Annually, DMA holds retirement seminars for persons within 1-5 years of retirement. In the Washington Metropolitan Area, more than 250 employees attended; in St. Louis, this seminar is scheduled for mid-November, and 60 employees have signed up to attend. Currently, efforts are being made to open these seminars up to employees with 12-15 years of Federal service.

c. One-on-one counseling sessions are offered to persons contemplating retirement.

d. DMA recently initiated a Wellness Program, which included the purchase of Kaiser Fitness equipment. This "air pressure" type of equipment is designed for ease of use by older persons. Also, "low-impact" aerobics, weight reduction seminars, cholesterol and blood screenings, and health risk screenings were offered. More than 600 DMA employees have taken advantage of the health screening offerings this year; 200 participated in the Body Composition assessments. Periodic

*Held on Committee files.

health-related lectures are offered and an average of 50-60 employees attend each session.

e. A total of 52 female employees over the age of 35 participated in obtaining mammograms through the Wellness Program this year.

f. An array of related printed brochures and pamphlets are available to all DMA employees.

For the Director:

CURT DIERDORFF,
Deputy Director for Human Resources.

DEFENSE INFORMATION SYSTEMS AGENCY

1. Our agency has an Employee Assistance Program that provides counseling and referral services to employees involved in caring for elderly relatives as well as employees who fall in the category of "older Americans". Employees are encouraged to make effective use of the agency flexitime system which allows employees to begin their workdays early or later than the usual starting time; or to work compressed hours (9 hours a day for 8 days, 8 hours for 1 day and the 10th day off). Job sharing and part-time work schedules may also be requested by employees. Supervisors and managers are encouraged to approve employee requests whenever feasible. The leave transfer program, as well as a work-at-home schedule, are other benefits available to employees experiencing a medical emergency or caring for a family member experiencing a medical emergency. Retirement planning seminars are held periodically. Individual retirement counseling services are available upon request. Health benefits open seasons are held annually.

2. Opportunities for training, developmental assignments, and promotions exist and "older Americans" within and outside the agency are encouraged to apply for positions through the agency merit promotion program. This agency has demonstrated a history of utilizing the reservoir of talent found in the "older Americans" category by hiring retirees.

3. The point of contact is Ms. Joyce Turner of my staff who can be reached on (703) 692-3990 for additional information concerning this response.

JAMES A. RHODES,
Chief, Civilian Personnel Division.

DEFENSE INTELLIGENCE AGENCY

1. Defense Intelligence Agency activities with a focus toward the interests and needs of older members of our civilian work force include:

Monitorship of work force age/service profile to assess special needs for training or awareness initiatives.

Mid-Career Planning Seminar established to assist work force with personal, career and retirement planning issues, i.e. financial and estate planning etc.

Pre-Retirement Planning Seminars offered on a continuing basis.

Individual retirement counseling available to all personnel.

Health Promotion Program activities offered on a continuing basis, i.e. Body Comp Analysis, Cardiovascular assessments, vision and hearing screening, etc.

Employee Assistance Program established with a full-time counselor available in-house. Counselor is skilled in providing assistance in a broad range of areas applicable to older members of the work force, i.e. parenting, elder care etc.

2. For additional information or questions regarding this topic please contact Ms. Tina Valencik at 284-1337.

For the Director:

ARTHUR E. WALTERS,
Director, Office for Human Resources

DEFENSE CONTRACT AUDIT AGENCY

At the present time, the Defense Contract Audit Agency's activities in the subject area are limited to enrollment of eligible employees in Pre-Retirement Counseling, and offering flexible work schedules to personnel required to care for elderly relations.

DALE R. COLLINS,
Director, Personnel and Security Division.

ITEM 4. DEPARTMENT OF EDUCATION

December 13, 1991.

DEAR MR. CHAIRMAN: This is in reference to your letter of October 2 requesting the Department of Education's FY 1991 report chronicling activities on behalf of older Americans.

I am pleased to transmit this summary to you for inclusion in the Committee's annual report entitled, *Developments in Aging*.

If the Office of Legislation and Congressional Affairs can be of further assistance, please let me know.

Sincerely,

B. ROBERT OKUN,
Assistant Secretary.

Enclosures.

ENFORCEMENT OF THE AGE DISCRIMINATION ACT BY THE DEPARTMENT OF EDUCATION

The Department of Education's (ED) Office for Civil Rights (OCR) is responsible for enforcement of the Age Discrimination Act of 1975 (Act), as it relates to discrimination on the basis of age in federally funded education programs or activities. The Act contains certain exceptions which 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 Department of Health and Human Services (HHS) has published a general governmentwide regulation on age discrimination. Each agency that provides Federal financial assistance must publish a final agency specific regulation. In March 1990, ED's Final Rule implementing the Age Discrimination Act of 1975 was submitted for review to the Secretary of HHS. HHS granted conditional approval to ED's Final Rule in December 1990. ED-OCR is currently revising the Final Rule to incorporate HHS' comments and additional revisions made by ED. Following receipt of HHS' formal approval, the Final Rule will be transmitted to the Office of Management and Budget for review prior to publication. ED is enforcing the Act under the general governmentwide regulation until an ED specific regulation is published.

The Act gives OCR the authority to investigate programs or activities receiving Federal financial assistance from ED. OCR does not have the authority to investigate employment complaints under the Act. Employment complaints either are sent to the Equal Employment Opportunity Commission (EEOC), which has jurisdiction under the Age Discrimination in Employment Act of 1967 (ADEA) for certain types of age discrimination cases, or are closed using the procedures described below.

Under the governmentwide regulation, OCR forwards complaints alleging age discrimination to the Federal Mediation and Conciliation Service (FMCS) for resolution through mediation. FMCS has 60 days to mediate the age-only complaints or the age portion of multiple-base complaints. For complaints alleging discrimination on the basis of age and another jurisdiction (i.e., Title VI of the Civil Rights Act of 1964 (Title VI), 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/or Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of physical and mental handicap), the applicable OCR case processing time frames are tolled for 60 days (or until the complaint is returned from FMCS, whichever is earlier) to allow FMCS to process the age portion of the case. OCR notifies the complainant(s) of the duration of the tolling of the time frames.

If FMCS is successful in mediating a complaint filed solely on the basis of age within the 60 days allowed, OCR closes the case. If the case is not resolved, OCR investigates the allegations in accordance with the applicable OCR case processing time frames. If the case was filed on the basis of age and another jurisdiction (e.g., Title VI), an attempt first is made by FMCS to mediate the age portion of the case, as described above. If FMCS is successful in mediating the age portion of the case within the 60-day time limit, OCR then processes the other allegations in the complaint within the applicable OCR case processing time frames. If FMCS is unsuccessful in mediating an agreement between the complainant and the recipient on the age portion of the complaint, the case is returned to OCR, and OCR processes the complaint allegations in accordance with the applicable OCR case processing time frames.

OCR facilitates its working relationship with FMCS by designating regional contact persons who coordinate directly with FMCS. OCR also accepts verbal or facsimile referrals from FMCS after unsuccessful attempts at mediation, and grants 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.

Age complaints involving employment filed by persons over the age of 40 are referred to the appropriate EEOC regional office under the ADEA, and the OCR file is closed. EEOC does not have jurisdiction over age/employment complaints that involve persons under 40 years of age. If the complainant is under 40 years of age, and the complaint filed with OCR alleges only employment discrimination, the complainant is informed that there is no jurisdiction under ADEA, and the case is administratively closed.

OCR received 223 age complaints in FY 1991. Of these, 66 were age-only complaints and 157 were multiple bases complaints. As shown on Table 1, below, 141 of the 223 receipts were processed in OCR and 82 were referred to other Federal agencies for processing. The most frequently cited issues in the FY 1991 age complaint receipts were "selection for financial assistance," "student rights," "application for admissions to education programs," "identification of students for gifted and talented programs," "employment evaluation and treatment," and "academic evaluation and grading."

TABLE 1.—Fiscal year 1991 age-based complaint receipt

Processed in OCR.....	141
Referred to FMCS.....	53
Referred to EEOC.....	24
Referred to Other Federal Agencies.....	5
Total receipts.....	223

FMCS successfully mediated 10 of OCR's complaints during FY 1991. The most frequently cited issues of the cases were "student rights" and "application and selection for enrollment in education programs." After unsuccessful mediations, FMCS returned 42 other age-based complaints to OCR for processing, including 5 complaints that OCR had referred to FMCS in a previous fiscal year. Most of these 42 cases involved the issues of "application and selection for enrollment in education programs," "student rights," and "academic evaluation and grading."

During FY 1991, OCR closed a total of 203 age-based complaints, including 55 age-only complaints and 148 multiple-based age complaints. As shown on Table 2, below, the majority of the complaints were closed for administrative reasons.

TABLE 2.—Fiscal year 1991 age-based complaint closures

	<i>Number of closures</i>
Administrative closures—145:	
No jurisdiction, on referral.....	52
No jurisdiction, but referral to another agency.....	32
Incomplete complaints.....	21
OCR has jurisdiction, but another agency will process.....	13
Untimely complaint receipts.....	9
Other administrative reasons.....	18
Substantive closures—58:	
OCR's investigation found no violation.....	38
Complaint was withdrawn after achieving change.....	7
Mediation by another agency achieved change.....	7
Remedial action was completed or agreed-upon.....	6
Total closures.....	203

Of the 58 substantive closures, change was achieved in 20. The most frequently cited issues in the cases with change were "application and selection for enrollment in education programs," "student treatment," and "student rights."

At the end of FY 1991, there were 69 age-based complaints pending in OCR, including 22 that had been returned to OCR by FMCS for processing. OCR confined its age discrimination compliance activities to complaint investigations; no compliance reviews on age discrimination were conducted in FY 1991.

However, during the course of the year, OCR provided training on the Age Discrimination Act and the governmentwide regulation for approximately 50 employees in OCR's Chicago, Dallas, and San Francisco regional offices. Training on OCR's procedures for referring complaints to EEOC was also provided for 11 employees in OCR's Kansas City regional office. OCR has a pamphlet under development for the public on age discrimination in education. The pamphlet will be published after

ED's final Age regulation is approved. OCR also responded to seven requests by ED beneficiaries for technical assistance on age discrimination issues during FY 1991.

ADULT EDUCATION

The U.S. Department of Education is authorized under the Adult Education Act (AEA) as amended by the National Literacy Act (P.L. 102-73) of 1991, to provide funds to the States and outlying areas for educational programs and related support services benefiting all segments of the eligible adult population. The central program established by the AEA is the State-administered Basic Grants Program. The AEA has also provided funds for programs of workplace and English Literacy. In addition, the 1991 amendments established four new programs:

- State Literacy Resource Centers
- National Workforce Literacy Strategies
- Functional Literacy for State and Local Prisoners
- Life Skills Training for State and Local Prisoners

The above-mentioned programs are administered by the Office of Vocational and Adult Education through the Division of Adult Education and Literacy.

In addition, amendments to the AEA State-administered Basic Grant Program include, in part:

The authorization for competitive 2-year "Gateway Grants" by States to public housing authorities for literacy programs for housing residents.

A requirement for States to develop a system of indicators of program quality to be used to judge the success of State and local programs.

An increase in the State set-aside under Section 353 for innovative demonstration projects and teacher training from 10 to 15 percent, with two-thirds of that amount to be used for training of professional teachers, volunteers, and administrators.

A requirement of the new amendments that, in allocating Federal funds to local programs, that each State consider: past program effectiveness (especially with respect to recruitment, retention and learning gains of program participants), its degree of coordination with other community literacy and social services, and its commitment to serving those most in need of literacy services.

A requirement that each State educational agency receiving financial assistance under this program provide assurance that local educational agencies, public or private nonprofit agencies, community-based organizations, correctional education agencies, postsecondary educational institutions and institutions which serve educationally disadvantaged adults will be provided direct and equitable access to all Federal funds appropriated under this program.

A requirement that States evaluate 20 percent of grant recipients each year.

Generally, the purpose of the AEA is to encourage the establishment of programs for adults lacking literacy skills who are 16 years of age and older including older person or who are beyond the age of compulsory school attendance under State law. These programs will:

- (1) Enable adults to acquire the basic educational skills necessary for literate functioning;
- (2) Provide sufficient basic education to enable these adults to benefit from job training and retraining and to obtain productive employment; and
- (3) Enable adults to continue their education to at least secondary level completion.

In the past, the education of persons 60 years of age and older may not have been considered an educational priority in the United States. The 1990's may well be considered the decade of growth in educational gerontology. Demographics have tended to make this development inevitable. In 1990, of the 40,249,000 adults 60 years old and over, 5,460,000 have had 8 years of schooling or less (1990 census data). The high rate of under-education indicates a need for emphasizing effective basic skills and coping strategies in programs for older adults.

Many of the emerging work force participants, including a large number of older adults, lack the basic literacy skills necessary to meet the increased demands of rapid changes and new technology. Thus, employers will have to make training and retraining a priority in order to upgrade the labor force.

In 1990, the total number of participants in the AEA program was 3.5 million. The number of participants in the 45-59 year age range was estimated to be 406,405, up by approximately 76,000 over last year, and participation of the group 60 or older was 198,333, an increase of over 26,000. Currently, some 17.3 percent of all persons served in adult education programs were 45 years of age or older. In response to

these data, the Department of Education's Division of Adult Education and Literacy has focused attention on the educational needs of older Americans.

The adult education program addresses the needs of older adults by emphasizing functional competency and grade level progression, from the lowest literacy level, to providing English as a second language instruction, through attaining the General Education Developmental Certificate. States operate special projects to expand programs and services for older persons through individualized instruction, use of print and audio-visual media, home-based instruction, and curricula focused on coping with daily problems in maintaining health, managing money, using community resources, understanding government, and participating in civic activities.

Equally significant is the expanding delivery system, increased public awareness, as well as clearing houses and satellite centers designed to overcome barriers to participation. Where needed, supportive services such as transportation, as are outreach activities adapting programs to the life situations and experiences of older persons. Self-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 citizens centers, nutrition programs, nursing homes, and retirement and day care centers.

In conclusion, the Federal adult education program will continue seeking ways to meet the learning needs of older Americans. Increased cooperation among organizations, institutions, and community groups involved in this area at the national, State, and local levels should lead to increased sharing of resources and expanded services.

LIBRARY PROGRAMS

STATE-ADMINISTERED PROGRAM

Section 2(a)(2) of P.L. 101-254, the Library Services and Construction Act, authorizes the provision of funds to support improving State and local public library services for older Americans. Library service to the elderly is one of the priorities of Title I of the Library Services and Construction Act (LSCA), a State-formula grant program administered by Library Programs in the U.S. Department of Education. Annual reports on projects conducted at regional or local public libraries, funded in whole or in part with Federal funds under LSCA, are submitted by the State Library Administrative Agencies to the Library Programs office.

Statistics for projects completed in fiscal year 1989 (the latest year for which such data are available), indicate that \$2,152,964 in LSCA funds were expended nationwide for individual library projects specifically aimed at serving the elderly. This amount was matched by \$871,161 in State funds and \$6,049,859 in local funds, for a total of \$9,073,984.

Support was provided to purchase special materials such as large-print books, audio cassettes, vision aids, and health related or other materials of special interest to the elderly. Additionally, support was provided for special programs on health issues for the elderly, talking books, projects to combat illiteracy and to deliver reading materials to senior citizens' centers or homes. Assistance also was provided to libraries to develop intergenerational programs matching older adult volunteers with libraries offering after school literacy and reading skills programs for unsupervised school children after school hours.

DISCRETIONARY PROGRAMS

Under the Library Services and Construction Act, Title VI, the Library Programs office administers the Library Literacy Program which has been funded at approximately \$5 million since it began in FY 1986. While the program serves adults who wish to improve their literacy skills, 3 percent of the funded projects in FY 1989 had a component specifically targeted to older adults for activities such as: (a) providing tutoring and literacy materials at senior centers; (b) conducting needs assessments to provide appropriate adult basic reading materials for senior citizens in long-term care facilities; (c) offering a statewide workshop for librarians and literacy providers to organize and operate a seniors-teaching-seniors program; and (d) collaborating with senior groups to promote literacy programs. In addition, Library Programs administers the LSCA, Title IV, Library Services to Indian Tribes and Hawaiian Natives Program which also supports projects serving all age groups. Outreach to tribal elders is an important component of these projects.

POSTSECONDARY EDUCATION

The Office of Postsecondary Education administers programs designed to encourage participation in higher education by providing support services and financial assistance to students.

In fiscal year 1991, an estimated \$18 billion was made available in financial aid to students through the student assistance programs. Data on the age of recipients of financial aid are not generally available. However, data for the Pell Grant program, the largest grant program, indicate that 5 percent of all recipients were over age 40.

The Special programs for the Disadvantaged, commonly known as the "TRIO" programs, provide support services to those interested in pursuing a baccalaureate education, enrolled in baccalaureate education, or wishing to pursue a graduate or professional degree. Because age is not an eligibility criterion under most of these programs, data on the age of participants are not available.

In addition to these programs, the Office of Postsecondary Education supports innovative approaches to meeting the needs of older Americans through the Fund for the Improvement of Postsecondary Education (FIPSE). In fiscal year 1991, FIPSE continued funding for five projects dealing specifically with our aging population. These projects are:

National Center for Transition to Teaching (American University, Washington, D.C.). This is a feasibility study of a program to recruit and train career switchers and early retirees from government agencies and the military. The program offers students an MA and teaching certification and will prepare students for positions in needed subject areas. Information on the project's results will be disseminated nationwide.

Senior Faculty Monitoring Program (Temple University, Philadelphia, PA). This program establishes a Senior Teacher Mentoring Service using recently retired senior faculty as mentors for new and junior faculty. The project focuses on effective teaching and gives junior faculty access to the wisdom and experience of proven master teachers while enabling retired faculty to remain professionally productive.

Elderserve (Kansas State University, Manhattan, KS). Kansas State developed Elderserve, a project designed to provide students with intergenerational learning opportunities, while working to meet the needs of older residents in rural communities. Now in its second year, Elderserve has developed partnerships with 19 rural communities, four community colleges, and four Area Agencies on Aging.

Coordinated Student Involvement in Elder Care (Foundation for Long Term Care, Albany, NY). The Foundation has established a consortium of 11 elder care agencies and three colleges to provide hands-on experience for students with issues related to health care practices and policies for the elderly. Participating students work between 6 and 12 hours a week in an agency and receive competitive wages. The work experience is combined with an undergraduate seminar on long term care issues.

Generations Together (University of Pittsburgh, Pittsburgh, PA). This project utilizes retired engineers as consultants to engineering faculty at the University to develop case studies and as mentors to students as they solve these problems. As mentors, retirees provide students with exposure to the practical realities of the profession. This also enables retirees to remain active professionally.

NATIONAL INSTITUTE ON DISABILITY AND REHABILITATION RESEARCH SUPPORTED AGING PROGRAMS—1991

The National Institute on Disability and Rehabilitation Research (NIDRR) authorized by Title II of the Rehabilitation Act, has specific responsibilities for promoting and coordinating research that relates directly to the rehabilitation of disabled persons. Grants and contracts are made to public and private agencies and organizations, including institutions of higher education, Indian Tribes and tribal organizations, for the purpose of planning and conducting research, demonstrations, and related activities which bear directly on the development of methods, procedures and devices which assist in the provision of rehabilitation services.

The Institute is also responsible for facilitating the distribution of information concerning developments in rehabilitation procedures, methods, and devices to rehabilitation professionals and to disabled persons to assist them in leading more independent lives.

The Institute accomplishes its mission through the following programs:

- Rehabilitation Research and Training Centers
- Rehabilitation Engineering Centers

Research and Demonstration Projects
 Field-Initiated Projects
 Innovation Projects
 Dissemination and Utilization Projects
 Career Development Projects which include:
 Fellowships
 Research Training

Aging Supported Activities: Research and Training Centers

1. Rehabilitation Research and Training Center on Aging Rancho Los Amigos Medical Center Downey, CA

This Center is a collaborative effort between the Rancho Los Amigos Medical Center, the University of Southern California School of Medicine and the Andrus Gerontology Center.

Research addressed by the Center includes:

"Late Effects of Early Disability" which is focusing on the medical, psychological, and social variables to determine their impact on the disabled person over the years and to determine the types of services needed in order to continue independence in the community.

"Attitudes of and Toward Older Persons with Disabilities" is developing an *Older Adults Disability Scale* and an accompanying written technical manual for professional use.

"Identification of Home Safety Problems and Technological Solutions for Older Disabled Persons" is evaluating a range of commercially available products designed to improve medication taking compliance in older persons with recommendations to consumers and professionals regarding the utility of these product with feedback to the manufacturers regarding product features and how they can be modified if necessary. A home resource safety book which includes behavioral safety tips as well as products which can be recommended to improve home safety is also being developed.

"Policy and Funding Alternatives to Promote Community and Supportive Services for Older Persons with Disabilities" is examining and evaluating existing programs and legislation which address the various needs of older persons. The outcome will be a series of recommendations on alternative methods of funding programs that will maximize older persons' independence in their own homes and communities.

The Center's training activities are designed to improve knowledge and skills regarding rehabilitation and the older person and are targeted to students, practitioners in rehabilitation and other health related disciplines.

2. Rehabilitation Research and Training Center on Community Integration of Elderly Persons with Mental Retardation and Other Developmental Disabilities, Cincinnati Center for Development Disorders, Cincinnati, OH.

In conjunction with the University Affiliated Programs (UAP) in Illinois, Indiana, Kentucky, Minnesota, and Wisconsin, and the University of Ohio, this Center is focusing on research that will improve community integration of older persons with mental retardation and other developmental disabilities.

The coordinated research program consists of nine projects in four major concentration areas: fiscal and program policy analysis; detection of age related change; transition reactions and support services; and collaborative training between aging and MR/DD services.

Specific projects are as follows:

"An Analysis of Policy Issues in the Delivery of Community Based Services to Older Persons with Mental Retardation"—University of Minnesota

"Interagency Long-Term Care Funding for Family Sized, Small-scale Non Restrictive Community Living Options"—University of Kentucky

"Detection of Decline in Older Adults with Development Disabilities"—Indiana University

"Behavioral Capabilities Assessment and Intervention Strategies of Older Persons with Developmental Disabilities"—University of Cincinnati

"Transitions for Older Adults with Developmental Disabilities: Facilitation Family and Resident Adjustment"—University of Illinois

"Stress, Health and Social Supports Among Families and Caregivers"—University of Wisconsin

"Investigation of Retirement Practices in the MR/DD System" and "Expanding and Dissemination about Older Persons with MR/DD: Strategies for Networking Among Service Systems"—University of Akron

Rehabilitation Engineering Centers

1. Rehabilitation Engineering Center: Assistive Technology and Environmental Interventions for Older Persons with Disabilities, New York University at Buffalo, Buffalo, New York

This Rehabilitation Engineering Center is composed of a trans-disciplinary group of clinical and research faculty and also has participation by consumers. There are three research programs which represent the main elements of assistive technology utilization: consumer assessments, environmental design and assistive technology. These three research programs represent:

- the assistive potential of low and high technology devices,
- exploring the environment in which older persons with disabilities apply technology, and
- improving the public and private sector systems delivering assistive technology services.

Also included in the Center's plan are three programs addressing dissemination and utilization. These three programs are organized round the main elements of assistive technology service delivery which include:

- device utilization,
- professional education, and
- technical assistance.

Field Initiated Research Program

1. Chronic Pain Rehabilitation in the Elderly Medical University of South Carolina, Charleston, SC.

This 3-year project is studying the clinical efficacy of multidisciplinary chronic pain rehabilitation programs for treatment of older patients with chronic musculoskeletal pain. Research includes prospective studies of admission criteria, delineation of patient characteristics, description of treatment programs, measures of treatment outcomes, and comparison with younger participants. The final outcome will be an objective basis for clinical decisions regarding inclusion of elderly pain patients in treatment programs.

2. Evaluation of Adaptive Device Use by Older Adults with Mixed Disabilities, Thomas Jefferson University, Philadelphia, PA.

This project is examining the use of adaptive devices following two training conditions: traditional rehabilitation-centered training or an enriched home-based training program. The enriched home training program is designed to match the person's values, lifestyle, and constraints of the home environment to equipment need and appropriate use. The project outcome is useful information on the selection of equipment and training necessary in the use of equipment if the equipment is not abandoned.

3. The Effectiveness of Speech Therapy for Patients with Parkinson's Disease, University of Colorado, Boulder, CO.

This project's purpose is to evaluate the short- and long-term effectiveness of an intensive program of speech therapy on speech communication intelligibility in older patients with Parkinson's disease and to document physiological changes underlying successful treatment. The project will yield rehabilitative speech treatment protocols which have been experimentally demonstrated to improve speech communication intelligibility in this population.

4. Evaluation of Methods for the Identification and Treatment of Visually Impaired Nursing Home Residents, The Lighthouse, N.Y. Association for the Blind, New York, NY.

This 3-year project's focus is to implement, evaluate, and disseminate information on an intervention strategy designed to facilitate the identification and rehabilitation of older visually impaired persons in nursing homes. The intervention strategy being tested includes nursing home staff training to ensure identification of persons with visual problems; provision of standard eye care services to ensure that excess disability due to simple refraction error is avoided; and provision of low vision clinical and other rehabilitation teaching services to minimize the functional implications of vision loss due to age-related vision disorders.

ITEM 5. DEPARTMENT OF ENERGY

DECEMBER 10, 1991.

DEAR MR. CHAIRMAN: In response to your letter of October 2, 1991, requesting an update of the Department's current and upcoming activities of particular interest to older Americans, I am submitting the following report. The document describes de-

partmental activities of interest to senior citizens in the areas of energy efficiency programs, information collection and distribution, public participation, and research on the biological and physiological aging process.

I am pleased to contribute to your annual report of Federal activities and programs on behalf of older Americans.

Sincerely,

JAMES D. WATKINS,
Admiral, U.S. Navy (Retired)

Enclosure.

INTRODUCTION

The mission of the U.S. Department of Energy (DOE) is to develop energy policies and programs in support of the President's broad objectives for America's future: sustained, noninflationary economic growth; good stewardship of the environment; and long-term strategic security. President Bush requested the development of a National Energy Strategy (NES) in July 1989—more than a year before the Iraqi invasion of Kuwait. As the President directed, Secretary of Energy James D. Watkins crafted a strategy that emphasized reliance on market forces to balance our increasing need for energy at reasonable prices; our commitment to a safer, healthier environment; our determination to maintain an economy second to none; and our goal to reduce reliance on insecure energy supplies.

The President presented the NES to Congress and the American people on February 20, 1991. The NES is a comprehensive and balanced strategy for an energy future that is secure, efficient, and environmentally sound. It is designed to diversify U.S. sources of energy supplies and offer more efficiency and flexibility in the way energy is consumed. Over the next two decades, the NES will make the United States more energy efficient and enhance our competitiveness without resorting to regulations, taxes, or import fees that can hurt consumers and cost Americans jobs.

Implementation of the NES will, by the year 2010, reduce the U.S. economy's demand for oil by 3.4 million barrels per day while increasing the domestic oil production by 3.8 million barrels per day. The strategy will also have a very positive impact on the environment. The NES will reduce the potential threat of global warming, enhance air quality, improve water quality, and address solid waste problems. In short, the NES provides a road map to a more secure and cleaner energy future through greater energy and economic efficiency and new technology.

The following provides a brief survey of DOE programs and activities of particular interest to senior citizens.

ENERGY EFFICIENCY PROGRAMS

Weatherization Assistance Program.—The elderly and the handicapped receive priority under this program, which provides grants to States for the installation of insulation, weatherstripping, storm windows, heating and cooling system modifications, and other energy-saving measures in low-income homes.

In 1991, the Weatherization Assistance Program awarded \$194,399,994 of appropriated funds in grants to the 50 States, the District of Columbia, and nine Native American tribal organizations for the weatherization of homes of low-income families. To date, over 4 million homes have been weatherized with Federal, State, and utility funds; of these, an estimated 1.7 million were occupied by elderly persons.

State Energy Conservation Program.—The State Energy Conservation Program (SECP) was created to promote efficiency and reduce the growth of energy demand in States. Under this program, DOE provides technical and cost-shared financial assistance, and the States develop and implement comprehensive plans for specific energy goals. At present, all States, the District of Columbia, and U.S. territories participate in SECP.

The Energy Extension Service (EES) is a Federal/State partnership established to provide small-scale energy users with personalized information and technical assistance to facilitate energy conservation and the use of renewable resources. Started as a 2-year project in 10 States, the program was expanded nationwide by Congress after an evaluation demonstrated its effectiveness. All States, as well as U.S. territories and the District of Columbia, receive cost-shared grants to help individuals, small businesses, and local governments take practical conservation steps.

Senior citizens are eligible for services provided through SECP and EES (directly or indirectly). In addition, many States have developed and implemented projects specifically for this population sector. Examples include senior weatherization and training, hands-on energy conservation workshops, low-interest loan programs, senior energy savings months, and numerous seminars addressing the varied needs

of senior citizens. These projects are often cosponsored with agencies whose primary focus is on senior citizens. In FY 1991, \$16,620,000 was appropriated for SECP and EES.

INFORMATION COLLECTION AND DISTRIBUTION

The Energy Information Administration collects and publishes comprehensive data on energy consumption in the residential sector through the Residential Energy Consumption Survey (RECS) and the Residential Transportation Energy Consumption Survey (RTECS). The RECS includes data collected from individual households throughout the country, along with actual billing data from the households' fuel suppliers for a 12-month period. The data include information on energy consumption, expenditures for energy, cost by fuel type, and related housing unit characteristics (such as size, insulation, and major energy-consuming appliances). The RTECS collects data on characteristics of household vehicles and annual miles traveled. The RECS and the RTECS contain data pertaining to the elderly.

The results of these surveys are analyzed and published by the Energy Information Administration. The most recent RECS was conducted for calendar year 1990. Results of the 1987 RECS are reported in three publications: *Housing Characteristics 1987* (published May 1989); *Household Energy Consumption and Expenditures 1987 Part 1: National Data* (published October 1989); and *Household Energy Consumption and Expenditures 1987 Part 2: Regional Data* (published January 1990). Results from the 1990 RECS will be published in 1992. The next RECS will be conducted in the fall of 1993.

Housing Characteristics 1987 provides data, categorized by age of householder, on energy-related characteristics of housing, including the floor space of the housing unit and types of fuels used.

Household Energy Consumption and Expenditures 1987 Part 1: National Data, provides estimates of consumption and expenditures of electricity, natural gas, fuel oil, kerosene, and liquefied petroleum gas for elderly households. Also included in the report is a discussion of energy use and the elderly, which indicates that in 1987, the elderly used about 10 percent more energy to heat their homes than the nonelderly, even after adjusting for weather and size of the housing unit. Overall energy expenditures were less for the elderly for all end uses except space heating, which was 13 percent higher. Approximately 61 percent of the elderly's total energy consumption was for space heating, and about 38 percent of their total energy expenditures were for heating.

Household Energy Consumption and Expenditures 1987 Part 2: Regional Data provides energy consumption and expenditure data by four census regions and nine census divisions. These data are also presented by age of householder.

The most recent RTECS was conducted in 1988. Results of this survey are published in *Household Vehicles Energy Consumption 1988* (published February 1990). This publication presents data, categorized by age of householder, on vehicle characteristics, vehicle miles traveled, gallons of motor vehicle fuel consumed, and expenditures for motor vehicle fuel. The next RTECS was conducted in 1991, and a report will be published in 1993. Data from the 1988 RTECS show that the elderly drove fewer miles and used less vehicle fuel per household than the nonelderly. Vehicle fuel consumption and average miles traveled also differed among the elderly. Households with only one elderly adult spent an average of \$426 per household for vehicle fuel and drove 7,229 miles compared to two-adult households with a 60-year or older householder. These households drove an average of 14,058 miles and spent about \$808 per household.

The published reports can be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20401 and from the National Energy Information Center, 1000 Independence Avenue, S.W., Washington, D.C. 20585.

PUBLIC PARTICIPATION ACTIVITIES

During FY 1991, the Department of Energy continued to work with the National Energy and Aging Consortium, Inc., a network of more than 40 organizations from the public and private sectors. The National Energy and Aging Consortium (NEAC) is unique in that it brings Federal agencies together with national aging organizations and the private sector to discuss and implement solutions to the energy-related needs of the elderly.

The Office of Consumer and Public Liaison represents the Department in the Consortium by serving on the Federal Advisory Committee to the NEAC. Through participation in this group, DOE continues to exercise leadership in forming partner-

ships with a variety of organizations that have worked with elderly citizens to assist with their energy needs and concerns.

During 1991, the National Energy and Aging Consortium has been working with the Oklahoma Energy and Aging Consortium in a research project funded by the Administration on Aging which is designed to establish new State energy and aging consortia. DOE's representative attended, in an advisory role, a working conference entitled "Building Participants were drawn from eight States interested in forming State energy and aging consortia, including: Connecticut, Illinois, Michigan, New Mexico, Pennsylvania, Tennessee, Texas, and Virginia. The project's "National Dissemination Conference," to which representatives of all 50 States will be invited, is scheduled for January 29-31, 1992, in Washington, DC.

Throughout 1991, the Energy Department's staff has maintained open channels of communication with Federal agencies and departments to improve information exchange about energy assistance programs. This information exchange gives particular emphasis to programs that allow for attention to the elderly.

RESEARCH RELATED TO BIOLOGICAL AGING

In 1991, the Office of Health and Environmental Research (OHER) and the Office of Environment, Safety, and Health administered research that used the Department of Energy's (DOE) unique laboratory capabilities, and university-based research, to understand basic biological principles and the health effects of radiation and energy-related chemicals. As part of its research program, DOE sponsors two categories of studies that are peripherally related to biological aging. These are studies indirectly concerned with understanding biological changes over time and various biological processes, including those of aging. The Department continues research to characterize late-appearing effects induced by chronic exposures to low levels of physical agents.

Because health effects that are caused by chronic low-level exposure to energy-related toxic agents may develop over a lifetime, they must be distinguished from normal aging processes. To distinguish between induced and spontaneous changes, information on changes that occur throughout the lifespan is collected for both experimental and control groups. These data help characterize normal aging processes as well as the toxicity of energy-related agents. Additional studies are conducted to obtain a better understanding of the aging process itself. As in the past, lifetime studies of humans and animals constitute the major research related to biological aging. Research directly concerned with the aging process has been conducted at several of the Department's contractor facilities. Summarized below are specific research projects addressing aging that the Department sponsored in 1991.

Long-Term Studies of Human Populations

Through the Office of Environment, Safety, and Health, the DOE supports epidemiological studies of health effects in humans who may have been exposed to chemicals and radiation associated with energy. Information on lifespan and aging 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 (RERF), sponsored jointly by the United States and Japan, continued work on a lifetime follow-up of survivors of atomic bombings that occurred 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 also are conducted. No evidence of radiation-induced premature aging has been obtained.

After being accidentally exposed in 1954 to radioactive fallout released during the atmospheric testing of a thermonuclear device, a group of some 200 inhabitants of the Marshall Islands has been followed clinically, along with unexposed controls, by medical specialists at the Brookhaven National Laboratory. Thyroid pathology, which has responded well to medical treatment, has been prevalent in individuals heavily exposed to radioiodine.

Nearly 2,000 persons exposed to radium, occupationally or for medical reasons, have been studied at the Center for Human Radiobiology, Argonne National Laboratory.

Other Studies Currently Under the Auspices of the DOE Office of Health

A Los Alamos National Laboratory epidemiologic study of plutonium workers at three Department of Energy facilities. An estimated 15,000 to 20,000 workers will be followed in this retrospective mortality study.

A study of some 600,000 contractor employees at Department of Energy facilities who are being analyzed in an epidemiologic study to assess health effects produced by long-term exposure to low-levels of ionizing radiation.

The U.S. Uranium/Transuranium Registry, which is operated by the Hanford Environmental Health Foundation, is collecting occupational data (work, medical, and radiation exposure histories) as well as information on mortality in worker populations exposed to plutonium or other Transuranium radioelements.

Studies Using Laboratory Animals

Although epidemiological data from humans are the most relevant data for assessing health effects of chemicals or radiation in humans, supportive data from animal studies are also useful. These studies are under the auspices of the Office of Energy Research.

Because studies of Laboratory rodents with lifespans of 2 to 3 years provide such supportive data, DOE has used them in large-scale studies of the effects induced by low doses of ionizing radiation. Studies using rodents to study chronic effects of radiation are underway at the Lawrence Berkeley Laboratory, and the Oak Ridge National Laboratory.

Larger, longer living mammals (such as dogs) may represent better human surrogates for chronic diseases than do shorter-lived animals. Because of this, understanding the effects of energy related agents on longer-lived animals is also important. Several years ago, DOE initiated several studies using dogs that were exposed to a variety of energy related agents. These continue at Lovelace Inhalation Toxicology Research Institute and at Pacific Northwest Laboratory. Most of these studies are coming to closure. In these final phases, emphasis is being placed on data analysis and on pursuing new and creative methods of statistical analyses. This research should increase knowledge of lifespan, age-related changes, morbidity, mortality, and causes of death, as well as alterations in these characteristics that may be induced by radiation. Because of changes in its research goals and directions during the last few years, no additional studies in dogs have been initiated by DOE.

Research Directly Concerned With Aging

Interest in biological aging has continued in several of the Department of Energy laboratories and has resulted in additional research at the molecular, cellular, and organismal levels of biological organization. Examples include: (a) research at the Lovelace Inhalation Toxicology Research Institute on effects of age on lung function and structure of adult animals, and (b) the study and diagnosis via radiopharmaceuticals and new imaging devices of age-related dysfunctions of the brain and heart, including senile dementia, Alzheimer's disease, stroke, and atherosclerosis.

Trends and Prospects

Given the need to assess long-term and late-appearing effects of chemicals and radiation associated with energy, lifetime studies of animals and epidemiological studies of humans will continue. Because there is a critical need for better methods to predict effects of exposure to low levels of chemicals and radiation, DOE research into these areas in receiving ever greater emphasis. DOE research in areas of basic biological principles, gene sequencing and structural biology should ultimately lead to better understanding of such effects. Although lifetime studies involving short-lived species will continue, no new lifetime studies involving long-lived mammals are planned. Research to understand molecular and cellular mechanisms, including aging, will continue, as will studies to sequence the human genome. As a result, additional information on age-related changes in both animals and humans should be produced.

ITEM 6. DEPARTMENT OF HEALTH AND HUMAN SERVICES

DECEMBER 20, 1991.

DEAR MR. CHAIRMAN: On behalf of Secretary Sullivan, I am submitting the Department of Health and Human Services' annual report for 1991 summarizing the Department's activities on behalf of older Americans. We are pleased that we could

be of assistance in developing this material for inclusion in Volume II of the Committee's annual report, *Developments in Aging*.*

I hope the enclosed information will be of value to the Committee. Should your staff need further assistance, the point of contact on my staff is Barbara Clark on 245-6311.

Sincerely,

STEVEN B. KELMAR,
Assistant Secretary for Legislation.

Enclosures.

HEALTH CARE FINANCING ADMINISTRATION

LONG-TERM CARE

The mission of the Health Care Financing Administration (HCFA) is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 50 million aged, disabled, and poor Americans.

Medicaid and Medicare are the principal sources of funding for long term care in the United States. The primary types of care reimbursed by these programs of HCFA are skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and home health services.

HCFA's Office of Research and Demonstrations (ORD) conducts research studies of a broad variety of issues relating to long term services and their users, providers, costs, and quality. ORD also conducts demonstration projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, delivery mechanisms, and management alternatives to the present Medicaid and Medicare programs.

RESEARCH ACTIVITIES

Long term care research activities in ORD can be classified according to the following objectives:

- assessing and evaluating long term care programs in terms of costs, effectiveness, and quality;
- examining the effect of the hospital prospective payment system (PPS) on long term care providers;
- examining alternative payment systems for long term care; and
- supporting data development and analyses.

Because of interest in promoting noninstitutional care, and recent increase in the utilization of these services, ORD's research is examining the cost, quality, and effectiveness of the services in the home setting. These efforts include comparison of the quality, case mix, and cost of noninstitutional services as well as the examination of home care provided under different payment arrangements, e.g., fee-for-service versus capitation. As part of these efforts, some studies are developing groupings of patients in both institutional and noninstitutional settings that have similar expected outcomes. Such groupings are essential since home care serves so many different types of patients, some of whom may fully recover and some who, even under the best of circumstances, are still expected to continue to decline.

A major responsibility of ORD is assessing the effects of various Medicare and Medicaid programs and policies affects subacute and long term care services. Since the implementation of PPS for paying hospitals, ORD has been assessing the effects of this change on other parts of the health care system. Included in this research is the examination of the effects of the prospective payment system (PPS) on long-term care case mix, utilization, costs, and quality. Changes in the supply of long term care providers are also being studied. Major research projects are underway to analyze the appropriateness of post-hospital care and the course and outcomes of that care. In recent years, there has been increased emphasis on examining episodes of care rather than utilization of just one type of service. Medicare files, which link hospital with post-hospital care, continue to be analyzed to provide information on trends in the post acute care utilization of post-hospital care since the passage of the PPS legislation.

Several research studies by ORD are examining the course and outcomes of post-hospital care. After the implementation of PPS, there was increased interest in the post-acute care area because the resulting shorter average hospital stays were ex-

* Appendix I—Clinical Research Related to Aging Project Abstracts;
Appendix II—Summaries of Services Research and Research Training; and
Appendix III—Basic Research Related to Aging Project Abstracts are held in Committee files.

pected to increase patients' post-acute care utilization. In addition, another purpose of funding this research was to gather information about decision-making at the point of hospital discharge and the types of patients who are referred to the various post-acute modalities of care. These research studies involve collection and analysis of data in order to provide Medicare payment, quality assurance, and coverage policy recommendations relating to subacute care (e.g., home health care, nursing homes, and rehabilitation hospitals).

Efforts are also underway to improve the data bases, statistics, and baseline information upon which future assessment of needs, problem identification, and policy decisions will be based.

DEMONSTRATION ACTIVITIES

Demonstration activities in ORD include the development, testing, and evaluation of:

- alternative methods of service delivery for post-acute and long term care;
- alternative payment systems for post-acute and long term care services; and
- innovative quality assurance systems and methods.

In 1991, HCFA continued the operation of a major demonstration testing the effectiveness of community-based and in-home services for victims of Alzheimer's disease and other dementias. This project focuses on the coordination and management of an appropriate mix of health and social services directed at the individual needs of these patients and their families. During 1991, the enrollment of clients was extended to provide over time for sites to build up their caseloads.

HCFA recently completed the implementation of a major demonstration aimed at testing prospective payment for Medicare home health agencies. This program is being conducted in two phases. The first phase involves testing of prospectively established per-visit payment rates for Medicare covered home health visits. A second phase, scheduled to begin in late 1992, will test per-episode payment rates for an entire episode of Medicare covered home health services. Substantial effort also was devoted to the design and development of a multi-State demonstration program to testing innovative case-mix payment and quality assurance methods for nursing homes that participate in Medicare and Medicaid. This project is scheduled to begin in late 1992.

ORD also continued work on several other major initiatives to test innovative reimbursement strategies to promote cost containment and foster quality of care. ORD has devoted extensive effort to the testing of capitated payment systems for a combination of acute and long term care services, including conducting and evaluating the demonstration of Social/Health Maintenance Organizations (SHMOs) and implementing the Program for All-inclusive Care for the Elderly (PACE). The purpose of the PACE demonstration has the purpose of replicating a unique model of managed care service delivery for very frail community dwelling elderly, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. Work is underway to design a "second generation" model of the S/HMO that can be tested in a future demonstration. HCFA also completed the design of a demonstration testing capitated payments for community nursing organizations and the solicitation of project sites for this demonstration is scheduled to begin in late 1991.

Information follows on specific HCFA research and demonstrations.

Long-Term Care: Elderly Service Use and Trends

Period: August 1989-December 1990

Total Funding: \$245,249

Awardee: The Brookings Institution, 1775 Massachusetts Ave., N.W., Washington, D.C. 20036-2188

Investigator: Joshua Wiener, Ph.D.

The project has three objectives:

- An analysis of the financial status of nursing home users.
- An analysis of the determinants of home care use.
- Projections of the numbers and level of disability among the elderly and their use of long-term care services.

Data from the following major surveys will be used: the 1982-84 National Long-Term Care Surveys, the 1984-86 Supplement on Aging/Longitudinal Study of Aging, and the 1984 Survey of Income and Program Participation. Data will be analyzed using cross-tabulations, logistic and least squares regression analyses, and the Brookings/Intermediate Care Facility simulation model (updated and revised).

Draft papers on the determinants of home care use and the relationship between informal and formal home care use have been completed. A final report is due by the end of 1991.

A National and Cross-National Study of Long-Term Care Populations

Period: September 1984-June 1991

Total Funding: \$1,016,587

Awardee: Duke University, Center for Demographic Studies, 2117 Campus Drive, Durham, NC 27706

Investigator: Kenneth Manton, Ph.D.

Based on data from the 1982 and 1984 National Long-Term Care Surveys (NLTCSs), this project will forecast the size and the socioeconomic characteristics, health status, and cognitive and physical functioning capacities of the aged population in the United States into the middle of the 21st century. These projections are being compared with similar information from other countries. The findings will be useful for planning long-term care (LTC) programs for functionally impaired aged persons. The project has been expanded to conduct additional analyses on:

- Identifying clusters of characteristics that distinguish groups of functionally impaired aged persons living in the community and that are associated with differential patterns of use and expenditures of home health care services.
 - Comparing hospital and post-hospital experiences of persons in the 1982 and 1984 NLTCSs and relating these experiences to changes in their functional and health status in the interim. Ascertaining, as an extension of this analysis, whether there have been substitutions for different types of services over time in light of the patients' changed health and functional status. For example, are home health services used more in lieu of nursing home services?
 - Describing and comparing out-of-pocket health care expenses relative to aged persons' health status, functional and cognitive disabilities, and access to informal caregiving services.
 - Examining the impact of institutionalization and the medical expenses incurred prior to and after institutional placement on the spouse who is not institutionalized. This analysis will include the impact of one spouse's institutionalization on the other spouse's economic, residential, health, and functional status as well as the Medical spend-down process as experienced by the noninstitutionalized spouse.
 - Refining the calibration of the underwriting factors used in computing the adjusted average per capita cost for establishing the capitation rates for aged Medicare enrollees joining health maintenance organizations and other prepayment plans. This will include combining detailed data on the functional and socioeconomic characteristics of the aged population from the 1982 and 1984 NLTCSs with Medicare utilization and expenditure data.
 - Converting the data tape from the 1984 NLTCS to a format suitable for public distribution.
 - Estimating what the Medicare expenditures would have been in 1982 and 1984 had the provisions of the Medicare Catastrophic Coverage Act (MCCA) of 1988 been in effect. (This was added to the project's scope of work in January 1989.)
- Public use data tapes from the 1982 and 1984 NLTCSs are available from the National Technical Information Service (NTIS). There are three parts to the package and each may be purchased separately.
- Documentation for the data tapes is available in paper copy or microfiche. The accession number is PB88-172267.
 - Data from the 1982 and 1984 NLTCSs are available in two separate tapes. One contained data on persons interviewed in 1982 and 1984. This provides the longitudinal perspective on persons in the surveys. The second contains data on all persons who participated in the 1984 NLTCS including data on aged persons who became Medicare beneficiaries after the 1982 survey was conducted. This provides a cross-sectional perspective on functionally impaired aged Medicare beneficiaries in 1984. The 1984 data on persons in nursing homes are more complete than the data obtained in 1982. The accession number is PB88-172242.
 - Medicare Part A bill data for services received between 1978 and 1985 by persons participating in the NLTCSs constitute the third tape. The coding scheme permits person-level linkage of the bill file to person participating in the surveys. The accession number is PB88-172259.

In addition, the report entitled *A National and Cross-National Study of Long-Term Care Populations* is available from NTIS, accession number PB89-190342. This report covers all the tasks described except for the modification added in January

1989—estimating the impact of MCCA on Medicare expenditures had the provisions been in effect in 1982 and 1984. Among the salient findings were:

- The number of elderly persons in the United States who might need LTC services in the community or in institutions because of impairments in activities of daily living is expected to increase from about 6.8 million in 1985 to 19.0 million in 2040.
- Given optimistic assumptions about continuing decreases in the mortality rate, the number of elderly persons with functional impairments in activities of daily living could be as great as 23.6 million by 2060.
- These estimates could be significantly affected by prevention or improved treatment of disabling conditions such as arthritis. A 50-percent reduction in the prevalence of arthritis would reduce, by 2040, the number of persons with arthritis 1.5 million below current projections.

Findings also show that diseases for which we know the most about risk factors and control (e.g., heart diseases, stroke, and cancer) are lethal diseases that produce relatively little long-term disability. In contrast, the diseases that are not as well studied and for which we have fewer effective controls (e.g., dementia, osteoporosis, rheumatoid arthritis, and osteoarthritis) are chronic degenerative diseases that produce the most long-term disability. Thus, without considerable new research on these and other disabling diseases, total life expectancy is likely to increase more rapidly than disability-free life expectancy. This will tend to increase the prevalence of disability and the need for LTC services.

The report estimating what Medicare expenditures would have been in 1982 and 1984 had the provisions of the Medicare Catastrophic Coverage Act been in effect is expected to be completed in late 1991.

Long-Term Care Survey

Total Funding: \$150,000

Agency: National Institute on Aging

Investigator: Kenneth Manton, Ph.D.

The Office of the Assistant Secretary for Planning and Evaluation and the Health Care Financing Administration agreed to transfer funds to the National Institute on Aging (NIA) to support an existing NIA grant to Duke University, Center for Demographic Studies. This grant, number 1R37AG07198, is entitled Functional and Health Changes of the Elderly, 1982-1989. The National Long-Term Care Survey (NLTCS) is a detailed household survey of persons 65 years of age and over who have some chronic (90 days or more) functional impairment. The survey has been administered three times. The first, conducted in 1982, was devised as a cross-sectional survey. The second, conducted in 1984, added a longitudinal component to the sample design. The third, administered in 1989, used the cohorts from the previous surveys in addition to persons becoming 65 years of age to form a nationally representative sample of impaired elderly persons. To facilitate the use of the data base, the following tasks related to the 1982, 1984, and 1989 NLTCSs will be carried out under this agreement:

- File linkage over the entire 1982-1989 period.
- Derivation of new longitudinal sample weights.
- Linkage of Medicare administrative records.
- Improvement of coding by checking consistency of survey items.
- Improvement in survey documentation.
- Seminars and education.

Funds for work relating to the 1989 NLTCS were just awarded. Weights for the 1982-1984 surveys have been revised. A file with Medicare Part B records has been prepared. File clean-up and documentation improvement for 1982-1984 NLTCS are proceeding.

Medicaid Tape-to-Tape: Research Data and Analysis

Period: March 1986-March 1991

Total Funding: \$5,141,406

Contractor: SysteMetrics, Inc., 104 West Anapamu St., Santa Barbara, CA 93101

Investigator: Suzanne Dodds

This project continues the development and implementation of a Medicaid person-level data set from the 5 State Medicaid Management Information Systems (MMISs) in California, Georgia, Michigan, New York, and Tennessee. Data on enrollment, claims, and providers for 1985 through 1988 will be acquired. These data will be used to create uniform files, provide descriptive reports, support analysis and evaluation, and develop methodology for online data base management. This project will provide a continuum of 9 years of uniform Medicaid data for analyzing program

management, evaluating policy alternatives, and providing feedback to States in the area of Medicaid financing.

This contract has been completed. Person-level enrollment, claims, and provider data have been produced. Project staff have also linked the data base to other kinds of health statistics to expand the uses of the data. The project produced summary tabulations on: enrollment, utilization, and expenditure data for each year and each participating State. Research topics included: capitation in Medicaid, mental illness, inpatient hospital use by Medicaid children, hospital reimbursement, Medicaid drug utilization, services to pregnant women and infants, physician volume, acquired immunodeficiency syndrome, long-term care, and Medicaid providers. The following reports have been published:

- Adams, E.K., Ellwood, M.R., and Pine, P.L.: Utilization and Expenditures under Medicaid for Supplemental Security Income Disabled. *Health Care Financing Review*. Vol. 11, No. 1, HCFA Pub. No. 03286. Health Care Financing Administration, Office of Research and Demonstrations. Washington. U.S. Government Printing Office, Fall 1989.
- Andrews, R.M., Keyes, M.A., and Pine, P.L.: Acquired Immunodeficiency Syndrome in California's Medicaid Program, 1981-84. *Health Care Financing Review*. Vol. 10, No. 1, HCFA Pub. No. 03274. Health Care Financing Administration, Office of Research and Demonstrations. Washington. U.S. Government Printing Office, Fall 1988.
- Burwell B., Adams E.K., and Mieners, M.: Spend-down to Medicaid Eligibility Among Nursing Home Recipients in Michigan. *Medical Care*, Vol. 28, No. 4, April 1990.
- Health Care Financing Administration: *High Volume and High Payment Procedures in the Medicaid Population*. Report to Congress, HCFA Pub. No. 03289. U.S. Department of Health and Human Services. Washington. September 1989.
- Howell, E.M., and Brown, G.A.: Prenatal, Delivery, and Infant Care under Medicaid in Three States. *Health Care Financing Review*. Vol. 10, No. 4 HCFA Pub. No. 03284. Health Care Financing Administration, Office of Research and Demonstrations, Washington. U.S. Government Printing Office, Summer 1989.
- Ray, W., Griffin, M., and Baugh, D.: Mortality Following Hip Fracture Before and After Implementation of the Prospective Payment System. *Archives of Internal Medicine*. Vol. 150, No. 10, pp. 2109-2114.
- KU, L., and Ellwood, M.R.: Deciphering Medicaid Data: Issues and Needs. *Health Care Financing Review*. 1990 Annual Supplement HCFA Pub. No. 03311. Health Care Financing Administration, Office of Research and Demonstrations. Washington. U.S. Government Printing Office, December 1990.
- Herz, E., Andrews, R., Ruther, M. and Dodds, S.: Access to Hospital Care for California and Michigan Medicaid Recipients. *Health Care Financing Review*. Vol. 12, No. 4, HCFA Pub. No. 03318. Health Care Financing Administration, Office of Research and Demonstrations. Washington. U.S. Government Printing Office, Summer 1991.
- Howell, E., Herz, E., Wang, R. and Hirsch, M.: A Comparison of Medicaid and Non-Medicaid Obstetrical Care, October, 1983. *Health Care Financing Review*. Vol. 12, No. 4, HCFA Pub. No. 03318. Health Care Financing Administration, Office of Research and Demonstrations. Washington. U.S. Government Printing Office, Summer 1991.

Medicaid Data Needs

Period: August 1991-July 1992

Total Funding: \$93,690

Awardee: RAND Policy Center, 1700 Main St., Santa Monica, CA 90406

Investigator: Steve Long, Ph.D.

In order to assist HCFA in its efforts to evaluate the current Medicaid data systems this project will (1) develop a list of important Medicaid policy issues and define several research studies to address these issues, (2) inventory the data needed to conduct these research project, (3) review existing data systems and identify gaps, and (4) propose ways that the gaps may be filled. By enumerating the data needs of a variety of different types of projects and evaluating data systems in light of those needs, the study will identify data activities necessary to support Medicaid health services research.

This project is in the early development stage.

Medicaid Analysis Project for States

Period: September 1990-September 1992 (3 optional years)

Total Funding: \$2,019,523

Contractor: SysteMetrics/McGraw-Hill, 104 West Anapamu St., Santa Barbara, CA 93101

Investigator: Suzanne Dodds.

The general purpose of this contract is to extend the collection and data activities of person-level data from Medicaid Management Information Systems (MMISs) maintained by the States. Data will be collected for the five States that are currently participating in the Medicaid Tape-to-Tape project while providing an appropriate interface with the Medicaid Statistical Information System (MSIS). Activities will include standard descriptive tabulations, Early Returns reports, and feedback to the State Medicaid agencies. The focus of work will be to:

- Obtain person-level data on Medicaid enrollment, use, payments, and providers from State MMISs.
- Develop uniform data file structures to facilitate the comparison of Medicaid programs among States.
- Produce streamlined research data bases to support analysis of policy and program management alternatives for Medicaid.
- Provide a consistent complementary link between tape-to-tape activities and the developing MSIS.
- Produce person-level data files from the MSIS to study the validity and consistency of these data for research.

Long-Term Care Studies

Period: September 1989–September 1994

Total Funding: \$3,790,234

Contractor: Health and Sciences Research, Inc., 9300 Lee Highway, Fairfax, VA 22031

Investigator: David Kennell, Ph.D.

The purpose of this project is to conduct research related to the HCFA's Medicare and Medicaid programs in the area of long-term care (LTC) policy development. The project will focus primarily on four major areas:

- The financial characteristics of Medicare beneficiaries who receive or need LTC services.
- How the Medicare beneficiaries' characteristics affect their utilization of institutional and noninstitutional LTC services.
- How relatives of Medicare beneficiaries are affected financially and in other ways when beneficiaries require or receive LTC services.
- How the provision of LTC services may reduce expenditures for acute care health services.

Analyses will use existing LTC and other survey data bases (e.g., the National Long-Term Care Surveys, the Longitudinal Study of Aging, the National Nursing Home Survey, the Survey of Income and Program Participation, and the National Medical Care Expenditure Survey). Medicare administrative records and other extant information will also be utilized. A number of focused analytic studies, policy reports, syntheses, and special studies are required under the contract.

The analytic plan for this project has been completed and number of studies have been initiated, and a few draft reports have been received. With the repeal of the Medicare Catastrophic Coverage Act of 1988, this project is no longer congressionally mandated.

The development of the 1989 enrollee, claims and provider files is underway. A second year of funding will allow for development of 1990 data.

An Analysis of the Impact of Prescription Drug Coverage for Aged Medicare Beneficiaries

Period: August 1989–August 1992

Total Funding: \$889,741

Awardee: Gerontology Center, College of Health and Human Development, The Pennsylvania State University, 210 Henderson Building South, University Park, PA 16802

Investigator: Bruce Stuart, Ph.D.

The purpose of the cooperative agreement is to conduct four coordinated studies of prescription drug use among the elderly, using the data base from the Pennsylvania Department on Aging's Pharmaceutical Assistance Contract for the Elderly (PACE) data base, linked with Medicare Part A and B claims data and eligibility and death information. The studies include: longitudinal analysis of PACE cohorts, demand characteristics of established insureds, prescription drug use in the last year of life, and drug-risk analysis.

All of the analyses are underway; linkage with the Medicare Part A and B data is in progress.

Medicare Catastrophic Coverage Act Evaluation: Beneficiary and Program Impacts

Period: September 1989–August 1994

Total Funding: \$2,187,621

Contractor: Abt Associates, Inc., 55 Wheeler St., Cambridge, MA 02138

Investigator: David Kidder, Ph.D.

The purpose of the contract is to perform a series of research projects all related to the analysis of the benefit changes introduced by the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360). Issues to be examined include the effects of the Medicare Part A changes instituted during 1989 and then revoked by Congress, effective 1990; and the effects of the Medicaid expansions, which were not revoked, on pregnant women and children, on dually entitled aged persons, and on community-based spouses of institutionalized Medicaid recipients.

Work on the contract was suspended until November 1990 pending the revision of the contract commensurate with the rescission by Congress of the Medicare aspects of the MCCA benefit. Work is underway on several of the Medicare analyses and the Medicaid analyses are pending the approval of selected Medicaid administrators.

Medicare Catastrophic Coverage Act Evaluation: Impacts on Industry

Period: September 1989–August 1994

Total Funding: \$993,199

Contractor: The Urban Institute, Health Policy Center, 2100 M Street, NW., Washington, D.C. 20037

Investigator: Marilyn Moon, Ph.D.

The purpose of the contract is to perform a series of research projects all related to the analysis of the benefit changes introduced by the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360). Categories affected by these benefit changes include hospitals, nursing homes, and home health agencies.

Work on the nursing home and home health analyses are in progress. Work on the hospital impacts analysis awaits data from the American Hospital Association.

Determinants of Home Care Costs

Period: August 1990–July 1991

Total Funding: \$125,140

Awardee: Brandeis University Research Center, 415 South St., Waltham, MA 02254

Investigator: Korbin Liu, Ph.D.

The major aim of this project is to develop a better understanding of the relationship between economic and program status and formal home care use and costs. The relationship between health status (i.e., functional, cognitive, and medical) and the use and costs of formal home care will be examined. If data permit, the analysis will be expanded to include informal home care. If this is possible, the mix of formal and informal care received by individuals can be explored. Data from Connecticut Community Care, Inc., will be used.

This project is finalizing the study design and determining the data elements and the study sample to be drawn from the agency records.

Demand for Formal and Informal Home Care Among the Functionally Impaired Elderly in the Community

Period: August 1991–March 1992

Total Funding: \$16,000

Contractor: Fu Associates, 2300 Clarendon Boulevard, Suite 1400, Arlington, VA 22201

Investigator: Judy Sangl

This project is providing programming support for an analysis of the demand for home care. The 1984 National Long-Term Care Survey is the primary database being used for the analysis. A synthetic market price will be created from Medicare home health charges and merged with the 1984 survey for the analysis.

The project is in the early development stage.

Financing of Acquired Immunodeficiency Syndrome and Acquired Immunodeficiency Syndrome-Related Complex Treatment Costs by Medicaid and Medicare

Period: May 1990–April 1994

Total Funding: \$648,985

Awardee: Maryland Department of Health and Mental Hygiene Center for AIDS Services, Planning, and Development, 201 West Preston Street, Baltimore, MD 21201

Investigator: Julie Hidalgo, Sc.D.

The State of Maryland proposes to develop a longitudinal data base of persons with human immunodeficiency virus (HIV) from 1981 through 1991. The project is expected to provide related-illness information on the extent to which patient, provider, and payer characteristics influence cost and use of health services on expenditures in Maryland under the Medicaid and Medicare programs. There are four major aspects to the study. The first is to maintain the data systems of the Maryland Human Immunodeficiency Virus Information System as required to measure program use and financing. The second is to compare and refine three different disease-staging approaches for predicting resource consumption and treatment outcome during the course of the HIV disease. The third is a retrospective assessment of health services used by pediatric, adolescent, and adult patients with HIV. The fourth is to use annual utilization, reimbursement, and financing data to measure trends.

The first year of the project has been completed. The 1990 Medicaid data have been obtained and data analysis has begun. Development of the Medicare data is in early stages.

High-Cost Hospice Care

Period: August 1990–July 1991

Total Funding: \$54,941

Awardee: Project HOPE Research Center, 2 Wisconsin Circle, Suite 500, Chevy Chase, MD 20815

Investigator: Burton Dunlop, Ph.D.

The purpose of this project was to identify what constitutes "high cost" Medicare hospice care, including per patient costs, long stay patients and/or services that are high-cost and determine or estimate the average cost of these services.

A panel of clinical experts was convened to discuss the dimensions of use of high-cost procedures. Dimensions of use include measures such as the number of patients receiving hospice services, frequency and duration of use these services, the diagnoses involved, and trends in the use of these procedures for palliation versus curative care. The particular focus is on pain control techniques used in hospice care. The report analyzes data on a sample of 1,600 hospice patients identified as high cost by the participating Medicare certified hospices. The report also includes a literature review and abstracts, plus description of the Medicare hospice benefit. This project is complete. A copy of the final report entitled "High-Cost Hospice Care: Final Report," will be submitted to NTIS.

Long-Term Care Supply and Medicare Hospital Utilization

Period: August 1989–August 1990

Total Funding: \$47,986

Awardee: Abt Associates, Inc., 55 Wheeler Street, Cambridge, MA 02138

Investigator: Robert Schmitz, Ph.D.

The purpose of this project was to investigate how local variations in the availability of nursing home beds affect Medicare hospitalization rates. Effects on the number of admissions, the number of hospital readmissions, the number of hospital days used, and the costs per Medicare Part A enrollee were evaluated. Urban and rural differences were assessed. The impacts of community long-term care services, Medicare risk-contract health maintenance organization services, and the prospective payment system on Medicare Part A utilization were evaluated.

Analyses have been completed and a final report has been received.

Impacts of Long-Term Care Supply Differences on Medicare Service Use

Period: August 1990–February 1991

Total Funding: \$80,204

Awardee: Brandeis University Research Center, 415 South St., Waltham, MA 02254

Investigator: Christine Bishop, Ph.D.

This study will identify and assess methodological and practical problems associated with a potential investigation of access to long-term care (LTC) service and the resulting impact on beneficiary use of Medicare-covered services. These services include hospital care, Medicare-covered home health care, and Medicare-covered skilled nursing facility care. The project will directly address issues, which have been studied in various models, of the effects of LTC access and supply on utilization of health services. The project will also develop a suggested study design on this topic.

A draft conceptual model for this study has been submitted to HCFA and is being reviewed. The final report is expected in December 1991.

Categorization of Nursing Homes and Rehabilitation Facilities

Period: August 1991–July 1992

Total Funding: \$94,362

Awardee: University of Minnesota Research Center, 1919 University Ave., St. Paul, MN 55104

Investigator: Robert Kane, M.D.

This study will identify the factors that differentiate the type and intensity of rehabilitative and other post-acute services provided to Medicare beneficiaries in nursing homes and rehabilitative facilities. Using these characteristics, a classification system will be developed of post-acute institutional providers based on the amount of rehabilitative care they provide. This will provide information on the extent of overlap in the provision of rehabilitative services by these facilities and relate the identified patterns of care to institutional characteristics. The study will also test the feasibility of the classification system in a pilot project using a sample of nominated rehabilitation facilities and nursing homes and propose a study design for further refinements of the classification system and analysis of related issues.

The project is in the early developmental stage.

Testing the Predictive Validity of Using Medicare Claims Data To Target High Cost Patients

Period: August 1991–May 1992

Total Funding: \$139,898

Awardee: Brandeis University, 415 South St., Waltham, MA 02254

Investigator: Christine Bishop, Ph.D

This study will investigate the feasibility of using historical Medicare claims data on patients hospitalized with certain primary diagnoses in order to identify a subset of patients who are more likely to incur high levels of Medicare reimbursements in the future. Analysis will be restricted to a sample of hospital patients with selected illnesses where: (1) past research indicates the specific patient diagnosis eventually results in higher Medicare costs; and (2) it is determined that targeted case management or coordinated care programs can be potentially effective (based on research and/or professional clinical judgment) in reducing overall health care costs.

This project is in the early developmental stage.

Analysis of Home Health Cost and Service Utilization Issues

Period: September 1991–July 1992

Total Funding: \$189,607

Awardee: University of Minnesota Research Center, 1919 University Ave., St. Paul, MN 555104

Investigator: Barbara Phillips, Ph.D

This study will prepare a synthesis of research findings related to prospective payment and analyze Medicare claims data to examine several aspects of prospective payment methodologies for home health agencies, such as outlier cases and volume adjustments. These analyses would provide information to advise HCFA in the future development of prospective payment methodologies for Medicare home health services.

This project is in the early developmental stage.

Efficacy of Nursing Home Preadmission Screening

Period: June 1988–December 1990

Total Funding: \$376,698

Awardee: Brown University, Division of Biology and Medicine, Providence, RI 02912

Investigator: Mary E. Jackson, Ph.D

In recent years, more than 30 States have adopted some form of preadmission screening (PAS), although the scope and methodology of programs vary considerably. The objective of this study was to analyze the extent to which 4 States' screening instruments accurately predict the need for nursing home level of care or an equivalent level of care provided in the community. The study focused in particular on the preadmission screen used by the State of Connecticut, with the goal of identifying possible refinements that would more appropriately place long-term clients in a cost-effective setting. This screen is designed to identify those persons who would be institutionalized if community-based services were not available. Brown University analyzed the extent to which the screen accurately predicts the need for a nursing home level of care or an equivalent level of community care. Control group subjects from State community-based service demonstration experiments in Georgia and South Carolina and from the National Long Term Care Channeling Demonstration.

The cooperative agreement was completed in December 1990. The findings indicated that the four-State screens varied in their degree of restrictiveness as well as in their ability to correctly predict those at risk and not at risk of nursing home admission. The study found clear trade-offs between higher rates of specificity and lower rates of sensitivity relative to the less restrictive screens—i.e., the more stringent screens were more likely to make false negative errors (excluding from eligibility persons at risk of nursing home admission), while the less restrictive screens were more likely to make false positive errors (identifying as at-risk individuals who would not become nursing home residents). Because of the large number of variables associated with the probability of nursing home use, and the necessity of excluding variables such as age, sex, race, and place of residence from a screen used to determine eligibility for publicly funded services, none of the four screens were able to predict correctly more than 60 percent of the time. A final project report has been submitted, and should be available from NTIS by December 1991.

National Recurring Data Set Project: Ongoing National and State-by-State Data Collection and Policy/Impact Analysis on Residential Services for Persons with Developmental Disabilities

Period: August 1991–September 1992

Total Funding: \$50,000

Awardee: The Administration on Developmental Disabilities Room 336-D, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201

Investigator: Charles Lakin, Ph.D.

HCFA's transfer of funds to the Administration on Developmental Disabilities (ADD) is in support of an existing ADD grant to the Institute on Community Integration, Center for Residential and Community Services at the University of Minnesota. The supplement provided by HCFA will support the conduct of secondary data analyses and the production of a report which will describe and update the status of persons with mental retardation and related conditions in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), Medicaid waiver programs and nursing homes funded under Medicaid in order to assist in the evaluation of Medicaid services for persons with mental retardation and developmental disabilities, and to point out areas in need of reform. The report will include:

- (1) a background description of the key Medicaid programs of interest;
- (2) state-by-state and national statistics on ICF/MR, Medicaid Home and Community-Based Services, and nursing home utilization; and
- (3) a description of the characteristics of ICF/MR facilities and their residents, with comparative statistics for noncertified facilities.

The project is in the early developmental stage.

Urban/Rural Variation in Home Health Agency and Nursing Home Services

Period: September 1989–November 1990

Total Funding: \$155,096

Awardee: Brandeis University Research Center, 415 South St., Waltham, MA 02254

Investigator: Christine Bishop, Ph.D.

Brandeis University and The Urban Institute compared urban and rural home health services and nursing home services to determine variation between provider characteristics and service utilization patterns. The underlying cost structures of urban and rural home health agencies were studied as well. This study is national in scope and utilizes several Medicare data bases for analysis.

The following reports have been prepared by under this study:

Kenney, Genevieve: *Home Health Use Patterns in Rural and Urban Areas: Are They Different?*, May 1991

Kenney, Genevieve: *Access to Home Health Services: Is It a Problem for the Rural Elderly?*, May 1991

Kenney, Genevieve: *The Provision of Home Health Services: Is It a Problem in Rural Areas?*, October 1990.

Dubay, Lisa: *The Provision of Nursing Home Services: Is There a Problem in Rural Areas?*, November 1990

Dor, Avi, et al.: *The Characteristics of Nursing Home Residents: An Urban-Rural Comparison*, October 1990

Dubay, Lisa: *Explaining Urban-Rural Differences in Skilled Nursing Facility Benefit Use*, June 1991

Dor, A., and Bishop, C.: *Medicare Costs in Urban and Rural Nursing Homes: Are Differential Payments Required?*, May 1991

These reports indicate that the proportion of Medicare beneficiaries using home health services and the average number of visits per user is greater in urban areas.

Within rural areas, use rates increase with population density. A greater proportion of home health visits provided to rural home health users are skilled nursing services, possibly substituting for reduced availability of physical, speech, and occupational therapists in rural areas.

This study found that the supply of nursing home beds per 1,000 Medicare beneficiaries is higher in rural areas, but rural nursing homes are more likely to provide intermediate care facility (ICF) level rather than skilled nursing facility (SNF) level care. Access to the Medicare SNF benefit appears to be greatest in large metropolitan areas, followed by rural areas, with enrollees in small and medium-sized areas having less availability of beds. The study suggests that the hospital swing-bed program appears to be an important element of access to post-hospitalized SNF level care in rural areas.

One additional report is scheduled to be completed in late 1991. After review by HCFA, all reports will be submitted to the National Technical Information Service.

Analysis of Cost, Patient Characteristics, Access, and Service Use in Urban/Rural Home Health Agencies

Period: September 1989–November 1990

Total Funding: \$103,420

Awardee: University of Minnesota Research Center, 1919 University Ave., St. Paul, MN 55104

Investigator: John Nyman, Ph.D.

The purpose of this project is to study urban and rural differences in home health agency costs, patient characteristics, access to care, and service utilization patterns in the State of Wisconsin. The study includes two types of analysis:

—Costs, patient characteristics, and service utilization patterns using home health care data from Wisconsin.

—Access to home health care services using patient-level Medicare data. In this component, Mathematica Policy Research, Inc., as subcontractor for the project, will apply two of the "Aftercare Guidelines" to the Medicare plan of treatment data to develop a measure of access between urban and rural recipients of home health care.

This study has been completed. Two reports were prepared:

Cheh, V., Phillips, B., and Buckley, D.: *Access to Medicare Home Health Agencies: Differences Between Urban and Rural Areas*, December 1990. This report indicates that Medicare home health users in rural areas of Wisconsin use fewer physical therapy services than in urban areas, although it appears that rural home health agencies may compensate by providing more restorative skilled nursing services.

Nyman, J., et al.: *Analysis of Costs, Patient Characteristics, Access, and Service Use in Urban and Rural Home Health Agencies*, May 1991. This component of the study estimated a total cost function of home health agency costs in urban and rural areas of Wisconsin. The report indicates that urban residents in Wisconsin are more likely to be home health patients and to receive more visits, but that these differences may be explained by differences in the types of patients being served in these areas.

Both reports will be submitted to the National Technical Information Service in the fall of 1991.

Study of Medicare Home Health Agency Use of the Home Health "Case Management" Benefit

Period: September 1991–July 1992

Total Funding: \$42,925

Awardee: Project HOPE Research Center, 2 Wisconsin Circle, Suite 500, Chevy Chase, MD 20815

Investigator: Robin Stone, Ph.D.

This study will analyze Medicare claims and plan of treatment data for home health agencies (HHAs) in order to examine the provision of skilled patient management by HHAs. Recent information suggests that the use of this service has significantly increased in recent years as a result of changes in the interpretation of coverage requirements for home health care. This study will provide HCFA with information about the characteristics of patients who are receiving this service, the types of HHAs who are furnishing the service, and the extent of regional variation in its use.

This project is in the early development stage.

Study of Alternative Out-of-Home Services for Respite Care

Period: September 1988–February 1990

Total Funding: \$239,495

Awardee: Brandeis University Research Center, 415 South St., Waltham, MA 02254

Investigator: Christine Bishop, Ph.D.

This study examined the advisability of expanding the respite care benefit to cover out-of-home services such as those provided in a nursing home or an adult day care center as an alternative to in-home respite care. Brandeis University researchers assessed the advisability of broadening the respite care benefit to include alternative services, giving consideration to cost, access, quality of care, and the feasibility of implementation. This assessment was accomplished using information collected from existing data sets and from ongoing respite programs and demonstrations.

The final report has been received in the Office of Research and Demonstrations. The report includes that the designs of any new respite programs should consider both in-home and out-of-home respite care.

Evaluation of Life-Continuum of Care Residential Centers in the United States

Period: January 1985–September 1989

Total Funding: \$832,871

Awardee: Hebrew Rehabilitation Center for the Aged, 1200 Centre St., Boston, MA 02131

Investigator: Sylvia Sherwood, Ph.D.

The objective of this project was to obtain information about the characteristics of continuum of care residential centers (CCRCs) and their residents and to compare these characteristics with respect to quality of life and health, service costs, and utilization with those of elderly residents living in the community. Data were gathered from 20 CCRCs in Arizona, California, Florida, and Pennsylvania. These sites were stratified according to the type of contract offered (extended versus limited), the age of the facility, and the income levels of those enrolled. Three types of CCRC residents were selected from the sites for the study sample—new admissions (580), existing residents, both short- and long-stay residents (1,640), and residents who died just prior to or during the field data gathering period (660). Quality of life and service utilization data were gathered at 2 points in time, at baseline and 12 months later. Three types of comparison samples were employed:

A representative sample of elderly in their own homes or independent apartments (2,422).

A national sample of elderly living in congregate housing settings (2,350).

A representative sample of elderly who have died and for whom retrospective data are available for their last year of life (1,500).

The final report is expected in late 1991.

Study of Adult Daycare Services

Period: June 1989–January 1990

Total Funding: \$93,750

Contractor: Institute for Health and Aging, University of California, San Francisco, 3733 California St., San Francisco, CA 94143

Investigator: Rick Zawadski, Ph.D.

The purpose of this survey of adult day centers was to provide updated information on:

- Who the adult day centers serve.
- The number of centers there are and their location.
- The services the centers provide.
- The characteristics of operating these centers.
- Who funds these centers.
- The cost of operating these centers.
- Licensing, certification, and quality assurance standards governing these centers.
- How these characteristics vary by State.

Funding for the survey was obtained from the American Association for Retired Persons. All the known and designated adult day centers in the United States (over 2,100) were mailed a survey during February 1989. Responses were received from 1,425 centers in 49 States providing information on organizational structure, licensing and certification, client characteristics, operating time and attendance, services provided, staffing, program costs, and revenue. A contract was awarded to the University of California at San Francisco to perform the analyses of the survey data. The study found that most centers are nonprofit organizations. The service package available in adult day centers varies, but most centers include recreational therapy; meals and transportation; social work; nursing; personal care; and medical assessment. Clients are predominantly older persons who are physically and/or cognitive-

ly impaired. The average program enrollment was 37 and daily attendance was fewer than 20. The daily operating cost in 1989 was \$36, with over half of the centers operating at a deficit. Medicaid was the largest funding source of adult daycare. A draft final report on the analysis has been received and is being revised. The report is expected to be available by the end of 1991.

Activities of Daily Living Measurements as Determinants of Eligibility

Period: August 1989–October 1990

Total Funding: \$99,991

Awardee: Brandeis University Research Center, 415 South St., Waltham, MA 02254

Investigator: John Capitman, Ph.D and Korbin Liu, Sc.D.

This study will use data from the national Long-Term Care Surveys, the National Long-Term Care Channeling Demonstration, and the Social Health Maintenance Organization Demonstrations comprehensive assessment form to examine issues associated with defining and measuring activities of daily living (ADLs) for use as eligibility criteria for Medicare services. A cost analysis will be performed, and other issues associated with using ADL scores as eligibility criteria will be discussed. Among the questions to be addressed are:

—What level of ADL impairments is used to trigger eligibility?

—Which ADL items should be used?

—Under what circumstances should assessments be performed and by whom?

Three reports have been received. The first, "The Administration of Eligibility for Community Long Term Care," considers issues and makes recommendations on eligibility criteria; timing and setting of assessments; assessment items; assessor qualifications and training; and review and appeal procedures. The second, "Home Care for the Disabled Elderly: Predictors and Expected Costs," uses a Tobit estimation procedure on data from the 1982 National Long-Term Care Survey. Major predictors of the number of paid in-home visits per week include age, sex, living arrangement, number of informal helpers, income, and functional status. Cognitive impairment was not found to be a significant predictor. The parameter estimates then were used to simulate the cost of providing home care services to select populations based on various combinations of program eligibility standards and the costs of some anticipated behavioral responses to the institution of a home care program. The third paper was "Predicting Participation and Costs in a National Long Term Care Program: Lessons From the Social HMO." It explored how service utilization and costs might be like if there were a managed care approach to long term care, and how utilization and cost would vary with different participant characteristics. Once finalized, these reports will be submitted to NTIS.

Implementing Federal Regulations in Nursing Homes: A Conceptual Paper

Period: April 1990–September 1991

Total Funding: \$52,630

Awardee: University of Minnesota Research Center, 1919 University Ave., St. Paul MN 55104

Investigator: Judy Gerrard, Ph.D.

The purpose of this project is to develop a conceptual paper on the issues involved in regulation of use of psychoactive drugs in nursing homes, the range of problems that the long-term care community and Health Care Financing Administration (HCFA) surveyors might face in implementing these regulations, the quality of large-scale data bases available for examining these issues and problems, and the research designs that would be most appropriate for studying the impact of the HCFA guidelines on use of psychoactive drugs by nursing home elderly. Two expert panels will be used in this project: a Practitioner Advisory Panel consisting of five local practitioners in the long-term care community and a National Expert Panel of experienced researchers in psychoactive drug use by nursing home elderly.

This project is in the early developmental stage.

Goals and Strategies for Financing Long-Term Care

Period: August 1989–October 1990

Total Funding: \$95,409

Awardee: University of Minnesota Research Center, 1919 University Ave., St. Paul, MN 55104

Investigator: Mark Pauly, Ph.D.

The purpose of this project is to use concepts drawn from a number of disciplines—economics, decision sciences, policy analysis, sociology, and demography—to develop statements of possible objectives for long-term care insurance. Defining objectives will include an analysis of benefits and costs from potential changes in fi-

nancing and an analysis of expected behavioral changes in response to changes in financing. The meaning of these objectives will then be illustrated by applying them to several types of policy proposals:

Subsidization of private insurance.

Employer-provided insurance.

Whole-life versions of insurance.

Means-tested public insurance.

Medicaid-equivalent subsidies.

Catastrophic public insurance.

Public provision of information on Medicare coverage and the need for insurance.

Analyses have been completed and a final report is expected by October 1991.

Natural History of Post-Acute Care for Medicare Patients

Period: December 1986–September 1991

Total Funding: \$3,702,330

Awardee: University of Minnesota School of Public Health, 714 Washington Ave., St. Paul, MN 55414

Investigator: Robert Kane, Ph.D.

This is a study of the course and outcomes of post-acute care. It has two major components—an analysis of Medicare data to assess differences in patterns of care across the country and to determine the extent of substitution where various forms of post-acute care services are more or less available; and a detailed examination of clinical cases from the most common diagnostic-related groupings receiving post-acute care in a few selected locations. Measures of the complexity of the clinical cases will be developed using a modification of the medical illness severity grouping system. This project is jointly funded by the Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation.

The conditions specifically being examined in the clinical analyses are stroke, chronic obstructive pulmonary disease, congestive heart failure, hip fracture and hip replacement. The three locations from which patients were obtained for the case studies are Pittsburgh, Houston, and Minneapolis/St. Paul. Patients and caregivers were followed up with interviews 6 weeks, 6 months, and 1 year after their hospital discharge whether the patients were discharged to nursing homes, rehabilitation hospitals, or home. The results of direct observation of selected aspects of patients' functional ability over time were also recorded.

The study will provide extensive clinical and functional information about the kinds of patients who receive post-acute care and what happens to them.

The awardee has submitted a draft interim report of preliminary outcome results, which is being reviewed. The final report which is due in September 1992 will include cost comparisons.

Policy Study of the Cost Effectiveness of Institutional Subacute Care Alternatives and Services: 1984–92

Period: May 1990–April 1994

Total Funding: \$1,370,000

Grantee: University of Colorado Health Sciences Center, 4200 East 9th Ave., Box C-241, Denver, CO 80262

Investigator: Andrew Kramer, M.D.

The University of Colorado will assess which subacute institutional settings and combinations of services are most cost effective and provide more positive outcomes for various types of patients. The project will identify potential Health Care Financing Administration (HCFA) policy changes that might encourage use of the most appropriate settings and services. This 4-year project will use primary and secondary data from three previous HCFA-sponsored studies to compare quality, cost effectiveness, case mix, service mix, and utilization among institutional subacute care alternatives (e.g., skilled nursing facilities, and rehabilitation hospitals) within and between two time periods—1984–87 and 1990–92. This methodology is designed to determine the most cost-effective combinations of services and provider settings for different types of patients requiring subacute care—for stroke, hip fracture, ventilator dependent, and congestive heart failure.

Data collection instruments have been designed and are awaiting OMB clearance. Facilities are currently being recruited for the study. Secondary analyses with MADRS data are underway.

Bundling of Acute and Post-Acute Care Service in to Payments for an Episode of Care

Period: August 1990–November 1991

Total Funding: \$71,605

Awardee: University of Minnesota Research Center, 1919 University Ave, St. Paul MN 55104

Investigator: Robert Kane, Ph.D.

The University of Minnesota is preparing a report which examines the issue of combining or merging hospital and post-hospital care into a single payment.

This project will examine the concept of bundling payment for acute and post-acute care services into payment for an episode of care. The Health Care Financing Administration is interested in developing alternative approaches that would encourage organizations to manage an entire episode of care under a payment arrangement other than the present fee-for-service system. Under this study the University of Minnesota is preparing a report on the feasibility of different design options that examines alternative approaches for establishing payments and coordinating services. After this draft report is prepared, a technical advisory panel will be convened to review it. The draft report and panel comments and recommendations will then be synthesized into a final report.

In July 1991, the University of Minnesota convened a panel of technical experts to review and comment on an initial report prepared by the project. The panel included representatives from hospitals, rehabilitation facilities, nursing homes, and home health agencies. The project's draft report has been revised to reflect the comments of this panel and a final report is under review in HCFA.

Focused Analysis of Post-Acute Care (PAC) Use for Selected DRGs

Period: September 1991-March 1992.

Total Funding: \$149,313.

Awardee: Brandeis University Research Center, 415 South St., Waltham, MA 02254.

Investigator: James Lee, Ph.D.

This project will study, for selected DRGs, the characteristics of patients, their variation in types of and costs for post-acute care (PAC) use, their probability of being rehospitalized, and the potential effects of different outlier policies in a bundled payment system. The information from the study could assist HCFA in exploring possible designs of alternative payment models for acute and PAC services. The study would explore the development of payment methodologies that combine payment for acute and PAC services and that are sensitive to the risk associated with variations in types and costs of PAC use.

The analysis will use Medicare claims data and data from previous research studies. The specific DRGs to be included in the study would be chosen during the study design based on their predominance of patients who use PAC, the availability of data, and the variability in the types and cost of PAC use. The issues included in the analyses would include the distribution of patients within DRGs, the variation in types of and costs for PAC use, and the probability of being rehospitalized. The analysis also would model the potential effects of different outlier policies or other risk-adjusted payment approaches to bundle payments for hospital/post-hospital services.

This project is in the early stages of development.

Study of Post-Acute Care in HMOs: Implications for Bundling

Period: August 1991-June 1992.

Total Funding: \$83,577.

Awardee: The RAND Policy Research Center, 1700 Main St., Santa Monica, CA 90406.

Investigator: Peter Jacobson, Ph.D.

Evidence from previous research suggests that a number of different approaches for managing geriatric care are practiced in health maintenance organizations (HMOs). Several of these approaches appear to have potential for reducing costs and improving quality of care. Little is known about how HMO's handle discharge planning, make placement decisions, track patients, or evaluate treatment. This project would examine approaches used by innovative HMO's in the management of post-acute care. The study will identify HMO's with innovative approaches to the handling of post-acute care and conduct case studies of a sample of these organizations. The case studies will collect information on the approaches used to arrange, monitor, and evaluate post-acute care. Included will be information on which patients are targeted, how placement decisions are made and who makes them, how services are evaluated, and what conclusions experienced HMO's have reached on cost effective treatment approaches.

This project is in the early stages of development.

Prospective Payment System and Post-Hospital Care: Use, Cost, and Market Changes

Period: September 1985–January 1990.

Total Funding: \$706,118.

Awardee: Georgetown University, Center for Health Policy Studies, 2233 Wisconsin Avenue, N.W., Washington, D.C. 20007.

Investigator: William Scanlon, Ph.D.

The purpose of the project is to determine how much the hospital prospective payment system (PPS) shifts care from the hospital to skilled nursing facilities (SNFs) and home health providers and to analyze the impact of this shift on total costs to Medicare and on changes in SNF characteristics that are likely to cause an increase in use by Medicare beneficiaries in the future. Medicare claims will be analyzed to determine how PPS has affected total service use (i.e., hospital, SNF, and home health) and costs for hospital patients. In addition, SNFs will be surveyed to identify changes in nursing home patients, services, and market structure likely to affect Medicare use. The survey will be supplemented with data from the Medicare/Medicaid Automated Certification System (MMACS), SNF cost reports, and other sources.

Major project activities include:

—Completion of nursing home survey.

—Analysis of survey and MMACS data.

—Completion of 1982 and 1985 Medicare claims processing for pre- and post-PPS analysis.

The final report is expected by the end of 1991.

Changes in the Post-Hospital Care Utilization Among Medicare Patients

Period: August 1989–July 1991.

Total Funding: \$102,247.

Awardee: The RAND Policy Research Center, 1700 Main St., Santa Monica, CA 90406.

Investigator: Richard Neu, Ph.D.

In this project, a data file was created linking Medicare billing records for inpatient hospital and post-hospital care for 1987 and 1988. RAND is using this file to document changes in post-hospital utilization among Medicare patients. The analyses will include an examination of skilled nursing facility, home health agency, and rehabilitative hospital care.

Analyses are almost completed. A report of the findings is expected in fall 1991.

Analysis and Comparison of State Board and Care Regulations and Their Effect on the Quality of Care in Board and Care Homes

Period: September 1991–September 1992.

Total Funding: \$200,000.

Awardee: Office of the Assistant Secretary for Planning and Evaluation, Room 410–E, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, D.C. 20201.

Investigator: Catherine Hawes, Ph.D.

The Health Care Financing Administration has transferred funds to the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in support of an existing contract with the Research Triangle Institute (RTI). ASPE has funded RTI to conduct to study examining the relationship between the type and amount of state regulation and the quality of care in board and care homes. In addition, the study will document the characteristics of a large sample of board and care homes, their residents and owner/operators. HCFA's support will enable the contractor to (1) increase the project's sample size to allow the relationship between additional characteristics of board and care homes to be analyzed, and (2) conduct a more detailed field test.

The project is in the early developmental stage.

Study of Home Health Care Quality and Cost Under Capitated and Fee-For-Service Payment Systems

Period: June 1987–June 1992.

Total Funding: \$1,683,773.

Awardee: Center for Health Policy Research, 1355 S. Colorado Boulevard, Denver, CO 80222.

Investigator: Peter Shaughnessy, Ph.D.

This project is designed to evaluate service utilization, quality, and cost of Medicare home health care provided under capitated and noncapitated (fee-for-service) payment systems. The Center for Health Policy Research will collect patient-level, case-mix, and service use data on a sample of approximately 4,000 patients from 44 agencies nationwide. A random and stratified patient sample will be drawn from

both fee-for-service and capitated payment environments to assess and compare cost effectiveness of care, quality of care, and incentives to admit and provide care in the two payment environments. Secondary data analysis will also be completed on a sample of 10,000 Medicare beneficiaries using Medicare claims data to compare service use patterns among posthospital Medicare patients discharged to skilled nursing facilities, home health care facilities, and the community, as well as Medicare home health patients admitted from the community.

Primary data collection continues. An analysis of the secondary data has been completed and a preliminary report has been submitted which is currently under review in HCFA.

Home Care Quality Studies

Period: October 1989-March 1993.

Total Funding: \$2,642,445.

Contractor: University of Minnesota, School of Public Health, Box 197, 420 Delaware St., SE., Minneapolis, MI, 55455.

Investigator: Robert Kane, Ph.D.

This study will carry out research on the following topics:

- Quality of long-term care services in community-based and custodial settings.
- Effectiveness of (and need for) State and Federal consumer protections that assure adequate access to and protect the rights of Medicare beneficiaries who are provided long-term care services other than in a nursing facility.

The project focuses on in-home care, examining traditional home health services that are reimbursed by Medicare and Medicaid as well as personal care and supportive services which have more recently been covered by Federal and State sources of funding. Key project tasks include:

1. Development of a taxonomy clarifying the various objectives and goals ascribed to home and community-based care from the various perspectives of consumers, payers, and care providers.
2. Development and feasibility-testing of a survey design that would measure the extent of, need for, and adequacy of home care services for the elderly.
3. A study of variations in labor supply and related effect(s) on home care quality, as well as factors that contribute to these variations.
4. Recommendations to improve the quality of home and community-based services by identifying best practices and promising quality assurance approaches.

The first project task has been completed, and a report on this component has been submitted. The University of Minnesota is continuing work on each of the remaining primary tasks. The final report for this contract is expected in March 1993. This study will carry out research on the following topics:

- The quality of long-term care services in community-based and custodial settings.
- The effectiveness of (and need for) State and Federal consumer protections that assure adequate access to and protect the rights of Medicare beneficiaries who are provided long-term care services (other than in a nursing facility).

Development of Outcome-Based Quality Measures for Home Health Services

Period: September 1988-December 1992.

Total Funding: \$1,965,389.

Contractor: Center for Health Policy Research, 1355 S. Colorado Boulevard, Denver, CO 80222.

Investigator: Peter Shaughnessy, Ph.D.

The purpose of this contract is to develop and test outcome-based measures or indicators of quality for Medicare home health services. The measures are to be reliable and valid for use in monitoring and comparing quality of home health care across agencies, recognizing possible confounding factors such as case mix. Colorado has developed a set of quality indicator groups that it hopes to test in this study. The contractor will consider a broad range of possible outcome measures including health and functional status measures. Project staff will test outcome measures that are linked to specific diagnostic conditions and/or services and will test broad-based measures that are not so linked. They will also test measures that are more precise in the information provided and others that are more practical and less costly to administer. The key criteria for the selection of measures include feasibility, reliability, validity, difficulty in gaming the measures, impact on quality, access, and cost and burden of data collection to the Health Care Financing Administration and home health agencies.

The contract was awarded in September 1988. The contractor has completed literature reviews, a concept paper, a design report, and an Office of Management and

Budget reports clearance package. The contractor completed an extensive round of feasibility tests and submitted an interim report in May 1991. The project now is in the process of implementing the final phase of data collection from 40-45 home health agencies.

The Robert Wood Johnson Foundation (RWJF) has awarded a grant to the Center for Health Policy Research which complements this study. The RWJF grant focuses on adult non-Medicare home care services and populations and uses clinical panels to identify quality measures.

Develop and Demonstrate a Method for Classifying Home Health Patients to Predict Resource Requirements and to Measure Outcomes

Period: June 1987-December 1990.

Total Funding: \$968,332.

Georgetown University, Georgetown School of Nursing, 3700 Reservoir Road, NW., Washington, D.C. 20007.

Investigator: Virginia Saba, RN, Ed.D.

The purpose of this project was to develop a method for classifying patients that will predict resource requirements and measure outcomes of Medicare patients in certified home health agencies (HHAs). Data on 73 dependent variables were collected from the home health records of approximately 9,000 recently discharged Medicare patients drawn from a national sample of approximately 650 certified HHAs, stratified by size, ownership, and geographic location. The data were being analyzed using multivariate statistical techniques to determine which variables are most predictive of resource requirements. The identified relevant variables were incorporated into a classification method that categorizes patients according to predicted resource requirements. A data base of participating HHAs and the characteristics of their Medicare patients was created.

Analysis of the data collected in the study indicated that patients' nursing diagnoses and nursing procedures are important variables in explaining home health resource use and costs. The final report has been submitted and is being prepared for submission to NTIS.

Analysis of Home Health Cost and Service Utilization Issues

Period: September 1991-July 1992.

Total Funding: \$189,607.

Awardee: University of Minnesota Research Center, 1919 University Ave., St. Paul, MN 55104.

Investigator: Barbara Phillips, Ph.D.

This study will prepare a synthesis of research findings related to prospective payment and analyze Medicare claims data to examine several aspects of prospective payment methodologies for home health agencies, such as outlier cases and volume adjustments. These analyses would provide information to advise HCFA in the future development of prospective payment methodologies for Medicare home health services.

This project is in the early developmental stage.

Psychoactive Drug Use Among Nursing Home Elderly

Period: September 1989-July 1990.

Total Funding: \$97,600.

Awardee: University of Minnesota Research Center, 1919 University Ave., St. Paul, MN 55104.

Investigator: Judy Gerrard, Ph.D.

This study examined the extent of regular and prn, or as needed, psychoactive drug use among nursing home elderly and the possibility of appropriate and inappropriate use of such drugs in terms of the characteristics of nursing home residents and nursing homes. Researchers used existing, secondary-source data from two previous research studies for the analyses. The studies involved a retrospective review of the records of 8,000 randomly selected individuals residing in nursing homes from 1980 to 1987.

Researchers found that:

- Although the level of use for each class of drug tested was the same among the residents cohort and the new admissions cohort, different people comprised the user groups.
- There was a considerable change in the number of new admissions and residents who were either discontinued or initiated on the drugs following entrance to nursing homes.
- Applying the criteria based on the guidelines for antipsychotic drugs and for unnecessary drugs, half of the neuroleptic users in both admissions and residents

cohorts lacked a specific condition or diagnosis that would make such use eligible under these guidelines. Seventy-five percent of the antidepressant users had no documented diagnosis of depression.

These findings were reported in the following article:

Garrard, J., Makris, L., Dunham, T., et al: Evaluation of Neuroleptic Drug Use by Nursing Home Elderly Under Proposed Medicare and Medicaid Regulations. *JAMA*, Vol. 265 No. 4 pgs 463-467, January 23/30, 1991.

The final report has been submitted to NTIS.

Impact of OBRA Drug Regulations: Nursing Home Trends in Rates of Drug Use

Period: October 1991-July 1991.

Total Funding: \$25,000.

Awardee: University of Minnesota Research Center, 1919 University Ave., St. Paul, MN 55104.

Investigator: Judy Gerrard, Ph.D.

The purpose of this project is to study the impact of the first year of Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) on the use of psychotropic drugs in Minnesota nursing homes. An analysis of trends in rates of psychotropic drugs before and after the implementation of the OBRA Drug Regulations will focus on (1) the use of antipsychotic drugs (2) the use of anti-anxiety drugs, (3) the rates of ineligible use of antipsychotic drugs. Ineligible is defined as the use of an antipsychotic drug without the appropriate justification as defined in the HCFA Guidelines. All rates will be adjusted for nursing home case mix. Data for this statistical analysis will be patient information in the case mix reimbursement system, a secondary source data base available from the Minnesota Department of Health.

This project is in the early developmental state.

The Use of Medicaid Reimbursement Data in the Nursing Home Quality Assurance Process

Period: June 1988-August 1991.

Total Funding: \$132,930.

Awardee: Center for Health Systems Research and Analysis, University of Wisconsin-Madison, Room 300 Infirmary, 1300 University Ave., Madison, WI 53706.

Investigator: David Zimmerman, Ph.D.

The purposes of this project are: (1) to assess the feasibility of using Medicaid reimbursement data to target facilities and residents in the nursing home quality assurance survey process; and (2) to develop a set of quality indicators using resident assessment data. Medicaid reimbursement data on medication use, sentinel health event, and other indicators are being provided to surveyors in preparation for the field survey, to help target facilities for more intensive review, identify specific areas of deficient care, and identify individual residents for more detailed review. The objectives of the project are to:

- convert reimbursement data into specific quality of care indicators (QCIs);
- identify the Federal regulations for which the use of QCIs has the greatest potential benefit;
- develop and demonstrate in one State (Wisconsin) procedures for providing QCIs to survey staffs;
- assess the potential for implementing the system in other States; and
- develop a set of quality indicators, using resident assessment information,
- sometimes in combination with claims data, that can be used in the survey process, as part of the multi-state Nursing Home Case Mix and Quality Demonstration.

A program was implemented on December 1, 1990 in which a randomly assigned group of survey teams in two Wisconsin regions are provided information on 33 QCIs for each nursing facility prior to the survey. Surveyors use the QCI information in selecting residents for in-depth review and in determining whether care deficiencies should be cited. The surveyors complete and return a feedback report that documents the results of QCI residents' investigations. Through July 1991, QCIs were used in approximately 60 surveys, in addition to the 17 surveys using them in a pilot study.

Activities continue on the development of Quality Indicators (QIs) for the Multi-state Nursing Home Case Mix and Quality (NHCMQ) Demonstration. Twelve areas of care (domains) have been identified and approximately 120 QIs were developed within these domains. The draft QIs were reviewed in July 1991 by a clinical work group consisting of more than 60 nurses, social workers, physician, and other health-care professionals, as well as case-mix States' project staff. Subsequent to the work group's suggestions, revisions and additions have been made bringing the total number of QIs to more than 150. A research work group review is planned for Octo-

ber. Analyses on the NHCMQ data base will be conducted on the QIs in upcoming months.

Utility of Medicaid Claims Data for Deriving Nursing Home Quality Indicators

Period:

Total Funding: \$302,311.

Awardee: SysteMetrics, Inc., 104 West Anapama St., Santa Barbara, CA. 93101.

Investigator: David Klingman, Ph.D.

The goal of this project is to investigate the usefulness of claims data from Medicaid and Medicare administrative record systems as sources of nursing home patient treatment and outcome measures. The study will involve retrospective analysis of 1987 Medicaid and Medicare claims data and facility deficiency data from 4 States—California, Georgia, Michigan, and Tennessee. Currently, the only nationwide assessment of the quality of nursing homes consists of summaries of survey deficiencies. Previous research has indicated that deficiency data should be used with caution since the levels and types of citations vary widely both across and within States. The innovative element of this study is the identification, using routinely collected claims data, of questionable treatments and sentinel health events that are diagnosis codes for which hospitalization represents and adverse patient outcome of nursing home care. This study will examine the relationship among staffing levels, treatment patterns, and patient outcomes.

The nursing home quality of care indicators (QCI) have been reviewed and finalized by a Technical Expert Panel (TEP), the data collection plan has been completed, and data analysis has been initiated.

Financial Impact to Beneficiaries of Nursing Home Care

Period: August 1988–August 1990.

Total Funding: \$129,888.

Awardee: Brandeis University Research Center, 415 South St., Waltham, MA. 02254.

Investigator: Korbin Liu, Sc.D.

The project used The Urban Institute's Transfer Income Model-2 (TRIM-2) for State estimates and the Connecticut Nursing Home Inventory data base to calculate nursing home use and payments. TRIM-2 is a microsimulation model based on the 1984 Current Population Survey used in forecasting use and payments. The Connecticut Inventory data base contains patient-specific information on all nursing home patients (private and public) from 1977 to the present. In addition, the 1985 National Nursing Home Survey was used to analyze several dimensions of nursing home use. From the collected data, estimates for the nursing home patients' spend-down provision were made.

A report, "Changes in Duration and Outcomes of Nursing Home Stays: 1977–1985," was completed. The report concludes that changes have occurred in the overall composition of nursing home admissions from 1977 through 1985. The analysis indicates that nursing home patients have become older, more disabled, and more likely to have been admitted for terminal care. Another report was published in a journal: Liu, Korbin and Manton, Kenneth; "Nursing Home Length of Stay and Spend-down: in Connecticut, 1977–1985," *Gerontologist* 31(2):165–173, 1991. This article reports data on nursing home stays over an 8-year period, October 1977 to September 1985, are available. Person-specific records were merged with death certificates and Medicaid eligibility dates, and multiple stays for individuals were studied using life-table methodologies. One of the major study findings is the distribution of the length of nursing home stay based on person-level use (multiple stay rather than single stays is markedly different). For example, Connecticut's data based on person-level use indicates that 39 percent of an admission cohort are still residents at 2 years compared with only 16 percent based on single stays. This information has important implications for design of private insurance policies or public policy options. Another major finding is that approximately 21 percent of individuals not covered by Medicaid who enter nursing homes ultimately convert to Medicaid. The timing of spend-down was over 1 year for half of the individuals which is longer than indicated by some other studies. A final major finding is that the estimate of the proportion of Medicaid to total nursing home days is 55.3 percent. However, Medicaid's proportion to the cost of care is expected to be less because of the contribution from income of persons spending down. Once finalized, the report will be submitted to NTIS.

Use of Medicare Part A and Part B in Nursing Homes

Period: August 1991–July 1992.

Total Funding: \$100,000.

Awardee: Brandeis University Research Center, 415 South St., Waltham, MA 02254.

Investigator: Korbin Liu, SC.D.

This project will examine the relationship between Medicare Part A and Part B service use in nursing homes. This includes examining: (1) the extent to which Part B therapy services are used for patients with a fully or partially-covered Part A Skilled Nursing Facility (SNF) stay; (2) the patterns of physician visits to nursing homes; and (3) the overall Medicare Part A and B costs incurred in the nursing home by Part A covered patients.

The project is in the early development stage.

New Jersey Respite Care Pilot Project

Period: July 1988-September 1992.

Grantee: New Jersey Department of Human Services, 222 South Warren St., Trenton, NJ 08625.

Investigator: William Ditto.

The New Jersey Respite Care Pilot Project was established to provide the kind of support the frail elderly and functionally impaired need to remain at home. It was developed to learn if respite care services enhance and sustain the role of the family as caregivers and whether these services delay or avert institutionalization. The project is designed to measure the impact on both care recipients and their caregivers.

Respite care is provided under this program by using short-term and intermittent companion services; homemaker, home health aide, and personal care services; adult day care, both social and medical; and inpatient respite in a hospital or nursing home. In addition to these services, peer support, training, and counseling are being provided to family members. All of the services are available in either planned or emergency situations.

Federal funding of this statewide project began on July 1, 1988 and was originally scheduled to end on September 30, 1990. However, the project was extended until September 30, 1992 by the Omnibus Budget Reconciliation Act of 1990. During this study, respite care services have been provided to the families of over 2,000 elderly and disabled individuals.

Preliminary data indicate that a typical caregiver is a 64-year-old female. Approximately 40 percent of the caregivers are children of the care recipient, while another 40 percent are spouses. Over 80 percent assist with dressing and bathing and more than 60 percent help with toileting. Caregivers report that the lack of time for themselves, coupled with the related stress, are the most overwhelming aspects of providing care. A substantial number also find the physical aspects of caregiving particularly difficult.

Homemaker/home health aide services have been provided to 75 percent of the care recipients. In addition, 14 percent have used day care programs, while 17 percent have had overnight stays in nursing homes or residential care facilities. Approximately 25 percent of the care recipients utilized more than one service, although the typical service pattern consisted of one in-home visit. The average age of the care recipient is 78 with only 9 percent age 60 or under. The large majority of this group's medical problems appear age-related. Twenty-two percent of the care recipients have Alzheimer's disease or a related disorder. The evaluation of the project is being conducted by the Institute for Health, Health Care Policy, and Aging Research at Rutgers University.

Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged

Period: January 1980-June 1991.

Grantee: Texas Department of Human Resources, 701 West 51st St., P.O. Box 2960, Austin, TX 78769.

Investigator: Ernest McKinney.

The purpose of this project is to reduce the growth of nursing homes in Texas and, at the same time, expand access to community care services for needy Medicaid individuals. This objective is being accomplished by directly changing the operating policies of Texas' Title XIX and Title XX programs, specifically by eliminating the State's lowest level of institutional care, intermediate care facility II (ICF-II). Existing organizations responsible for the State's Title XIX and Title XX programs are responsible for project implementation.

The demonstration ended on June 30, 1991. Notable progress was made in achieving project objectives during the period of the demonstration. In March 1980, there were 15,486 individuals in the ICF-II group; as of July 1991, 17 ICF-II clients remained. From March 1980 to July 1991, the total institutional population was mar-

ginally decreased from 64,820 to 62,315 clients (a reduction of 3.9 percent), while the community care population increased substantially from 30,792 to 65,018 (an increase of 111.2 percent). A final report is expected in October 1991.

Evaluation and Technical Assistance of the Medicare Alzheimer's Disease Demonstration

Period: September 1989–September 1993.

Total Funding: \$1,999,812.

Contractor: Institute for Health and Aging, University of California, San Francisco, 201 Filbert St., San Francisco, CA 94133.

Investigator: Robert Newcomer, Ph.D.

The Medicare Alzheimer's Disease Demonstration was authorized by Congress under Section 9342 of Public Law 99-509 to determine the effectiveness, cost, and impact on health status and functioning of providing comprehensive services to beneficiaries who have dementia. Two models of care, are being studied under this project. Both provide case management and a wide range of in-home and community-based service, including homemaker and personal care services, adult day care, and education and counseling for family caregivers. The two models vary by the intensity of the case management beneficiaries and their families receive and the level of Medicare reimbursement that is available each month to pay for demonstration services. Clients are responsible for a 20 percent coinsurance just as they are under the regular Medicare program. There are four Model A and four Model B sites participating in this demonstration. Under Model A, each site has a case manager to client ratio of 1:100 and a monthly expenditure cap of \$300. Model A sites are located in Memphis, TN; Portland, OR; Rochester, NY; and Urbana, IL. The case management ratio in the Model B sites is 1:30 and their monthly expenditure cap is \$500. Model B sites are in Cincinnati, OH; Miami, FL; Minneapolis, MN; and Parkersburg, WV.

A provision in the Omnibus Budget Reconciliation Act of 1990 extended the demonstration from 3 to 4 years. It also increased the funding for the project's administrative and service costs from \$40 million to \$50 million and for the evaluation from \$2 million to \$3 million. During the first 2 years of the demonstration, the sites enrolled almost 5,000 Medicare beneficiaries, including both treatment and control group members. However, there has been an unexpectedly high client attrition rate. Most of the individuals who have left the project have been disenrolled because of death or nursing home placements. To compensate for this greater than anticipated attrition, client enrollment was extended until October 31, 1991. This additional time gives the sites an opportunity to enroll other Medicare beneficiaries to replace those who have died or been institutionalized.

Major questions to be addressed by the evaluation include:

- What factors are associated with the cost effectiveness of providing an expanded package of home care and community-based services to Medicare beneficiaries with Alzheimer's disease or related disorders?
- How do various services impact on the health status and functioning of dementia patients and their caregivers?
- What are the effects of providing community-based services on caregiver burden and stress?
- Do additional home care services delay or prevent institutionalization of beneficiaries with dementia?

The demonstration is scheduled to end in May 1993.

Prior and Concurrent Authorization Demonstrations

Period: September 1987–July 1992.

Total Funding: \$827,200.

Contractor: Lewin/ICF, 1090 Vermont Ave., Washington, DC 20005.

Investigator: Barbara Manard, Ph.D.

Under Section 9305 of Public Law 99-509, the Secretary of Health and Human Services is required to conduct a demonstration program concerning prior and concurrent authorization of post-hospital extended care services and home health services furnished under part A or Part B of Title XVIII. This legislation responds to concerns expressed by home health agencies (HHAs) and skilled nursing facilities (SNFs) that under the current system of Medicare payment they cannot adequately predict what services the fiscal intermediaries (FIs) will deny as noncovered. In recent years, the number of visits denied by FIs has increased steadily. It is hypothesized that prior authorization (PA) and concurrent authorization (CA) payment approaches will reduce the number of services denied without increasing Medicare expenditures. Under PA, providers submit treatment plans to FIs for review prior to the start of care; under CA, plans of treatment are submitted when care begins. In

both approaches, the provider receives notification from the FI about how many services will be covered. This provides greater certainty about coverage and payment before services are given.

The law requires that the demonstration include at least four projects and be initiated by January 1, 1987 and that the Secretary must evaluate the demonstration and report to Congress on the evaluation. The evaluation and report must address:

- The administrative and program cost for prior and concurrent authorization compared with the current system of retroactive claims review.
- The impact on access and availability of post-hospital services and timeliness of hospital discharges.
- The accuracy and cost savings of payment determinations and rates of claims denials compared with the current system.

The Bureau of Program Operations, Health Care Financing Administration (HCFA), implemented a home health concurrent authorization pilot project in July 1987. This project was initiated in Illinois and in the entire Dallas region and is still in progress. Lewin/ICF implemented the SNF demonstration in September 1989 at sites in Tennessee and Indiana. Lewin/ICF is responsible for evaluating both the home health pilot project and the SNF demonstrations in September 1989 at sites in Tennessee and Indiana. Lewin/ICF is responsible for evaluating both the home health pilot project and the SNF demonstration in September 1989 at sites in Tennessee and Indiana. Lewin/ICF is responsible for evaluating both the home health pilot project and the SNF demonstration.

A report to Congress based on Lewin/ICF's preliminary evaluation of the home health project and the design of the SNF project was submitted to Congress in August 1990. The SNF prior authorization demonstration ended in November 1990 and the home health pilot project ended in September 1991. Both an update of the home health pilot project results and the evaluation findings regards the SNF demonstration will be submitted to HCFA by February 1992.

Nurse Practitioner/Physician Assistant Aggregate Visit Demonstration

Period: October 1990–March 1992.

Total Funding: \$130,538.

Awardee: The Urban Medical Group.

Investigator: Jeffrey Kang, M.D., Rita Chung.

Under Section 6114(e) of the Omnibus Budget Reconciliation Act of 1989, the Medicare program provides Part B coverage for medical visits to nursing home residents provided by nurse practitioners who are members of a physician/physician assistant/NP team. Under this legislation, the number of visits supplied to any nursing home patient is limited to an average of 1½ visits per month.

Section 6114(e) mandates a demonstration project under which the visit limitation would be applied on an average basis over the aggregate total of residents receiving services from members of the provider team.

The project is in the early developmental stage. A demonstration project in Massachusetts ("Case Managed Medical Care for Nursing Home Patients"), which used nurse practitioners and physician assistants to provide visits to nursing home patients, ended on September 30, 1990. The study proposes to use these existing demonstration sites for the new OBRA-89 mandated project. This will effectively eliminate the need to recruit and/or train provider teams for new sites, and will allow the study to focus on operational questions and carrier capabilities. The project will be conducted in two parts: (1) a planning and development stage, which will include finalizing the research design, obtaining consent from all providers and patients, and software development and implementation by the carrier; and (2) the actual implementation and operation of the demonstration.

Evaluation of the New York State Quality Assurance System

Period: October 1989–September 1991.

Total Funding: \$349,477.

Contractor: Abt Associates, Inc., 55 Wheeler St., Cambridge, MA 02138-1168.

Investigator: Margot Cella.

The objectives of the New York State Quality Assurance System (NYQAS) are to link data from the case-mix reimbursement system for use in the quality assurance system and to integrate the quality assurance processes of survey/certification, inspection of care, and utilization review. The basis purpose of the evaluation is to determine which aspects of NYQAS are effective and those which are not, and why. It is hoped that this information will inform the implementation and monitoring of the Multistate Nursing Facility Case-Mix and Quality Projects, the nursing home reform provisions of OBRA-87, and the surveillance of nursing homes in general. Consistent with these objectives, the evaluation will employ a variety of qualitative

and quantitative methods to assess NYQAS' reliability and validity of problem identification, monitoring and enforcement, and the impact of NYQAS on the quality of care.

This project is in the early developmental stage.

Texas Nursing Home Case-Mix Demonstration

Period: September 1987-June 1992.

Total Funding: \$532,830.

Grantee: State of Texas Department of Human Services, P.O. Box 149030 (MC-E-601), Austin, TX 78769.

Investigator: Pam Coleman.

The Texas Department of Human Services will conduct a 3-year demonstration to implement and evaluate a Medicare/Medicaid prospective case-mix payment system. The payment system will be based on HCFA-sponsored feasibility studies. The major Medicaid objectives of the project are to:

- Match payment rates to resident need.
- Promote the admission of heavy-care patients to nursing homes.
- Provide incentives to improve quality of care.
- Improve management practices.
- Demonstrate administrative feasibility of the new system.

The objective for Medicare is to develop and pilot test administrative processes for implementing a Medicare prospective payment system based on a resource utilization group (RUG) system in coordination with Medicaid case-mix systems. Texas will use a quasi-experimental design for the Medicare pilot test to compare the effect of introducing case-mix payment in an experimental catchment area versus continuing the flat rate, cost-based system in a control catchment area. The State will use a pre-post design for the Medicaid system. The case-mix classifications are based on a review of 6 different systems in which the New York RUGs II explained the greatest variance of staff time. The case-mix indexes borrow major elements of the RUGs II system and some of the rationale from the Minnesota system. The Texas index of level of effort (TILE) uses 4 clinical groups to form clusters and develops subgroups using an activities of daily living (ADL) scale. The index that will be used for the classification of Medicare patients is the RUG-T18, which uses the same clinical groups and ADL scale used in the New York RUGs II system. The difference occurs in the expanded rehabilitation groups for Medicare patients. Two third-party evaluations—one of data reliability and a second of the validity of the data analysis methods—will be used.

During the first year, the TILE and RUG-T18 indexes reviewed for compatibility. The RUG-T18 classification was placed into operation to match the HCFA Medicare coverage guidelines effective April 1988. Cost analyses of both national and State samples of Medicare providers were performed to arrive at baseline costs for calculating the rates for the RUG-T18 groups. The Texas client assessment, review, and evaluation instrument has been reviewed and revised. The new national minimum data set (MDS) was tested on 900 residents, and the interrater reliability was found to be very good between the 2 instruments on similar items. The MDS will be used for Medicare classification. In the Medicare pilot, each week a nurse will review new admissions onsite to classify residents into the RUG-T18 groups and to give prior authorization of the Medicare stays for specific time intervals. The Medicaid payment system became operational in April 1989. Medicare waivers are being processed and the demonstration is scheduled for operation in late 1991 and will operate for 15 months.

The Multi-State Nursing Home Case-Mix and Quality Demonstration

Period: June 1989-June 1993.

Total Funding: \$931,755.

Awardees: State Medicaid Agencies.

This project builds on past and current initiatives with case-mix payment and quality assurance. The 5-year demonstration will design, implement, and evaluate a combined Medicare and Medicaid system in 4 States—Kansas, Maine, Mississippi, and South Dakota. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of outcomes adjusted for case mix. The new minimum data set plus (MDS+) for resident assessment will be used for resident care planning, payment classification and quality monitoring systems.

The project consists of 3 phases—systems development and design, systems implementation and monitoring, and evaluation. There will be 3 years of developmental

work before the Medicare/Medicaid classification and payment system will be ready for implementation in the demonstration States.

The project has conducted a field test of the MDS on 6,660 nursing home residents. The average direct-care staff time across the States is 115 minutes. A new multistate Medicare/Medicaid patient classification system containing 41 groups has been created. The States implemented the MDS+ in fall 1990 with the approval of the Health Standards and Quality Bureau. In collaboration with The Circle, Inc., and the University of Wisconsin, the States are beginning data analysis of service utilization and outcomes. The demonstration States are scheduled to implement the new payment system and quality monitoring information system in summer 1992.

Multi-State Case-Mix Payment and Quality Demonstration

Period: April 1990–April 1993.

Total Funding: \$661,613.

Awardee: New York State Department of Health and Health Research, Inc., Room 1683, Corning Tower, Albany, NY 12237.

Investigator: Steve Anderman.

New York State will participate in the multi-state Nursing Home Case Mix and Quality Demonstration (NHCMQ) presently in its development phase. The demonstration uses case-mix systems for both Medicare and Medicaid that are based on a common patient classification system. The objective of the demonstration is to test the feasibility and cost effectiveness of a case-mix payment system for nursing facility services under Medicare and Medicaid.

The addition of New York to the demonstration enhances HCFA's ability to project the results of the demonstration on a national basis. New York represents a heavily regulated, northern industrialized area with larger, high-cost nursing facilities that are medically sophisticated and highly skilled. Sixteen percent of the national Medicare skilled nursing facility days are incurred in New York State. New York is uniquely suited for inclusion in this demonstration since it has already implemented a complementary system for its Medicaid nursing facility payment program.

Project staff completed the minimum data set field test in early 1991 in 25 facilities on 902 residents. These data have been added to the data base analyzed to develop the new NHCMQ Medicare/Medicaid classification system. The data have resulted in the addition of a very high rehabilitation group to the upper end of the classification.

The State has begun analysis of cost data for use in the Medicare case-mix payment system.

Long-Term Care Case-Mix and Quality Technical Design Project

Period: September 1989–September 1991.

Total Funding: \$997,887.

Contractor: The Circle, Inc., 8201 Greensboro Drive, Suite 600, McLean, VA 22102.

Investigator: Bob Burke, Ph.D.

This 3-year contract will support the design and early implementation phase of the multistate Nursing Home Case-Mix and Quality Demonstration (NHCMQ). The demonstration combines the Medicare and Medicaid nursing home payment and quality monitoring system across several States. This project builds upon the past and current initiatives with nursing home case-mix payment and quality assurance in nursing homes. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of process and outcomes adjusted for case mix. The project will have three phases: (1) systems design and development, (2) systems implementation and monitoring, and (3) evaluation.

The classification system to be used across the States for Medicare and Medicaid was completed in June 1991 by researchers from Michigan and RPI. The groups are split on clinical conditions including signs and symptoms of distress, type and intensity of service, activities of daily living. The resource utilization groups version III (RUG-III) uses 41 groups to explain approximately 45 percent of the variance in nursing staff time and 50 percent of the costs across nursing, OT, PT, ST, transportation and social work services. The 27 groups at the top of the classification match the Medicare coverage criteria. A working paper describing the classification has been developed. The common assessment tool, the minimum data set plus (MDS+) has been published and implemented as the State resident assessment instrument (RAI) in the demonstration States.

Over the past year, approximately 100 quality indicators (QIs) on the MDS+ data were developed by the University of Wisconsin researchers. The QIs were reviewed for clinical meaningfulness by 60 health professionals representing about 15 disci-

plines working long term care. These will be revised and serve as the basis for analysis of the QIs to be used for the operational phase of the demonstration.

The Medicare payment task group began work in July 1991 and the payment design should be completed in early spring 1992. The demonstration is expected to become operational in summer 1992.

Reference: Feldman, Janet and Boulter, Cleo editors, *Minimum Data Set Plus (MDS+). Multistate Nursing Home Case Mix and Quality Demonstration Training Manual*, Natick, Ma, Eliot Press, 1991.

The Development of Long-Term Care Reform Strategy for New York's Office of Mental Retardation and Developmental Disabilities

Period: June 1988-December 1990.

Total Funding: \$115,581.

Awardee: New York State Department of Social Services, Division of Medicare Assistance, 40 North Pearl St., Albany, NY 12243.

Investigator: Howard Gold.

The New York Office of Mental Retardation and Developmental Disabilities is conducting a 2½-year project to develop a comprehensive plan and waiver application that would reform the financing, regulation, and service delivery of the mentally retarded and developmentally disabled (MR/DD) system in three districts covering eight New York counties. The State considers the demonstration as the first step toward statewide implementation. The objectives are to:

Develop a financing system that will improve services to the MR/DD population by expanding the number and types of people to be served and the types of services to be provided.

Change the manner in which quality of care is assured.

Constrain growth in Federal expenditures for these services.

Waivers would alter the Medical basis of payment, revise the State Medicaid plan requirements, change how Medicaid funds can be used, and implement revised quality assurance regulations. The demonstration will test an alternative financing approach that approximates recently formulated departmental policy directions as developed by the Department of Health and Human Services working group on intermediate care facilities for the mentally retarded. The project represents a major test of reform in the delivery of services for persons who are developmentally disabled.

Both national and State-level advisory panels have been convened and issue papers have been completed. The State has submitted a Medicaid 2176 home and community-based care waiver to implement this project in the fall 1991. A final report is expected by December 1991.

On Lok's Risk-Based Community Care Organization for Dependent Adults

Period: November 1983-Indefinitely.

Grantees: On Lok Senior Health Services, 1441 Powell St., San Francisco, CA 94133. California Department of Health Services, 714-744 P St., Sacramento, CA 95814.

Investigator: Marie Louise Ansak.

As mandated by Sections 603(c)(1) and (2) of Public Law 98-21, the Health Care Financing Administration granted Medicare waivers to On Lok Senior Health Services and Medicaid waivers to the California Department of Health Services. Together, these waivers permitted On Lok to implement an at-risk, capitated payment demonstration in which more than 300 frail elderly persons, certified by the California Department of Health Services for institutionalization in a skilled nursing facility, are provided a comprehensive array of health and health-related services in the community. The current demonstration maintains On Lok's comprehensive community-based program but has modified its financial base and reimbursement mechanism. All services are paid for by a predetermined capitated rate from both Medicare and Medicaid (Medi-Cal). The Medicare rate is based on the average per capita cost for the San Francisco county Medicare population. The Medi-Cal rate is based on the State's computation of current costs for similar Medi-Cal recipients using the formula for prepaid health plans. Individual participants may be required to make copayments, spend-down income, or divest assets based on their financial status and eligibility for either or both programs. On Lok has accepted total risk beyond the capitated rates of both Medicare and Medi-Cal with the exception of the Medicare payment for end stage renal disease. The demonstration provides service funding only under the waivers. The research and development activities are funded through private foundations.

Section 9220 of Public Law 99-272 has extended On Lok's Risk-Based Community Care Organization for Department Adults indefinitely, subject to the terms and con-

ditions in effect as of July 1, 1985, except that requirements relating to data collection and evaluation do not apply.

Frail Elderly Demonstration: The Program of All-inclusive Care for the Elderly

Period: June 1990–October 1993.

Grantees: See below.

As mandated by Public Law 99-509, as amended, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-inclusive Care for the Elderly (PACE) demonstration replicates a unique model of managed-care service delivery for 300 very frail community-dwelling elderly, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided extramurally. Transportation is also provided to all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The six sites and their State Medicaid agencies that have been granted waiver approval to provide services are:

Elder Service Plan

Period: October 1989–May 1993.

Grantee: East Boston Geriatric Services, Inc., 10 Gove St., East Boston, MA 02128.

Period: October 1989–May 1993.

Grantee: Massachusetts State Department of Public Welfare, 180 Tremont St., Boston, MA 02111.

Providence ElderPlace

Period: October 1989–May 1993.

Grantee: Providence Medical Center, 4805 Northeast Glisan St., Portland, OR 97213.

Period: October 1989–May 1993.

Grantee: Oregon State Department of Human Resources, 313 Public Service Building, Salem, OR 97310.

Comprehensive Care Management

Period: October 1989–August 1993.

Grantee: Beth Abraham Hospital, 612 Allerton Ave., Bronx, NY 10467.

Period: October 1989–August 1993.

Grantee: New York State Department of Social Services, 40 North Pearl St., Albany, NY 12243.

Palmetto Senior Care

Period: August 1989–September 1993.

Grantee: Richland Memorial Hospital, Five Richland Medical Park, Columbia, SC 29203.

Period: August 1990–September 1993.

Grantee: South Carolina State Health and Human Services, Finance Commission, P.O. Box 8206, Columbia, SC 29202.

Community Care for the Elderly

Period: August 1990–October 1993.

Grantee: Community Care Organization of Milwaukee County, Inc., 1845 North Farwell Ave., Milwaukee, WI 53202.

Period: August 1990–October 1993.

Grantee: Wisconsin State Department of Health and Social Services, P.O. Box 7850, Madison, WI 53707.

Total Longterm Care, Inc.

Period: August 1991–July 1994.

Grantee: Total Longterm Care, Inc., 1801 East 19th Ave., Denver, CO 80218.

Period: August 1991–July 1994.

Grantee: Colorado Department of Social Services, 1575 Sherman St., Denver, CO 80203.

Up to nine additional sites will be phased in over the next 2 years. A contract to evaluate the PACE demonstration was awarded in June 1991. Presentations of the demonstration implementation issues were given at the following national meetings: American Hospital Association Annual Meeting, Henry Ford System Annual Conference, Group Health Association of American Annual Meeting, National Council on Aging Annual Conference, Gerontology Association of America Summer Institute, Gerontology Association of American Annual Conference.

Evaluation of the Program of All-inclusive Care for the Elderly (PACE) Demonstration

Period: June 1991–February 1996.

Grantee: \$4,486,514.

Contractor: Abt Associates Inc., 55 Wheeler St., Cambridge, MA 02138.

Investigator: Larry Branch, Ph.D.

The Program of All-inclusive Care for the Elderly (PACE) demonstration has the purpose of replicating a unique model of managed care service delivery for 300 very frail community dwelling elderly, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary team case management through which access to and allocation of all health and long-term care services are arranged. Financing of this model was accomplished through prospective capitation of both Medicare and Medicaid payments to the provider.

The purpose of the evaluation is to examine PACE sites before and after assumption of full financial risk, with the purpose of determining whether the PACE model of care, as a replication of the On Lok Senior Health Services model of care, is cost-effective relative to the existing Medicare and Medicaid systems. Specific evaluation questions relate to the model of care and the effects of the model on participant utilization, expenditures and outcomes.

This contract was awarded in June 1991. An initial round of site visits has been completed and the evaluation design and data collection plan are being revised based on these site visits.

Program for All-Inclusive Care for the Elderly (On-Lok) Case Study

Period: August 1989–January 1991.

Grantee: \$172,138.

Awardee: University of Minnesota Policy Center, 1919 University Ave., St. Paul, MN 55104.

Investigator: Robert Kane, M.D.

This study will provide a descriptive analysis of the early stages of the Program for All-Inclusive Care for the Elderly (PACE) demonstration. The study will examine in detail the model of service delivery provided by On Lok Senior Health Services, San Francisco, California, and the degree to which aspects of this model are successfully replicated in eight sites nationwide. The results are expected to have utility as subsequent sites are developed for later implementation.

Two rounds of site visits to On Lok and PACE sites have been completed and an interim report has been submitted. A final report was received in September 1991. In addition to comparing eight PACE sites to On Lok on seven features of the PACE model, the researchers offer lessons learned from the first eight sites regarding replicability; sources of start-up and development funds, census building, staffing, and enrollee patient mix are seen as critical issues to future sites. Also offered are some issues to be faced by the evaluators, including the difficulty of selecting appropriate comparison groups, data equivalence across experimental and comparison groups, the need to collect additional data regarding enrollee outcomes (client and family satisfaction, affect, quality of life), and statistical power and the role of pooling.

Evaluation of the Suitability of Nonrandom Designs for the Program for All-Inclusive Care of the Elderly

Period: July 1990–September 1990.

Total Funding: \$14,494.

Awardee: University of Minnesota Research Center, 1919 University Ave., St. Paul, MN 55104.

Investigator: Roger Feldman, Ph.D.

The Health Care Financing Administration is implementing a demonstration project to test the replicability and cost effectiveness of the Program of All-inclusive

Care of the Elderly (PACE). This demonstration is designed to test a unique model of totally integrated, managed care service delivery for the very frail community dwelling elderly. Due to a variety of reasons, evaluation design in which eligible participants are randomly assigned to treatment and control groups is not feasible. The purpose of this project is to study the suitability of nonrandom designs for this demonstration.

This project is completed and the final report has been received. The report agrees that a random design is not appropriate for the evaluation of the PACE demonstration and that other methods could control for selection bias.

Quality of Care in the Program of All-inclusive Care for the Elderly (PACE) Model

Period: August 1991-July 1992.

Total Funding: \$60,117.

Awardee: University of Minnesota Research Center, 1919 University Ave., St. Paul, MN 55104.

Investigator: Robert Kane, M.D.

The purpose of this study is to develop measures to assess quality of care on both a routine and periodic basis in the Program of All-inclusive Care for the Elderly (PACE) model of care. These measures may be used in PACE site quality assurance programs and quality assurance monitoring undertaken by HCFA and State Medicaid agencies. Attention will be given to measures that reflect concerns relevant to both acute and long term care and the provision of that care in an integrated, capitated system.

This project is in the early stages of development.

Social Health Maintenance Organization Project for Long-Term Care

Period: August 1984-September 1992.

Grantees: See Below.

In accordance with Section 2355 of Public Law 98-369, this project was developed and is currently implementing the concept of a social health maintenance organization (S/HMO) for acute and long-term care. A 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. Four sites have been selected to participate in this project.

Of the four S/HMO demonstration sites selected, two are HMOs that have added long-term care services to their existing service packages, and two are long-term care providers that have added acute care service packages. The demonstration sites utilize Medicare and Medicaid waivers, and all initiated service delivery by March 1985. During the first 30 months of operation, Federal and State governments shared financial risk with the sites. This risk sharing ended August 31, 1987. This demonstration was extended twice by legislation. The current legislation (P.L. 101-508) extends the demonstration period through December 31, 1995. The S/HMO sites are:

Elderplan, Inc.

Grantee: Elderplan, Inc., 6323 Seventh Ave., Brooklyn, NY 11220.

Seniors Plus

Grantee: Group Health, Inc., and Ebsenezer Society, 2829 University Ave., SE., Minneapolis, MN 55414.

Medicare Plus II

Grantee: Kaiser-Permanente Center for Health Research, 4610 Southeast Belmont St., Portland, OR 97215-1795.

SCAN Health Plan

Grantee: Senior Care Action Network, 521 East Fourth St., Long Beach, CA 90802.

Evaluation of Social Health Maintenance Organization Demonstrations

Period: September 1985-November 1990.

Total Funding: \$3,547,934.

Contractor: University of California, San Francisco, Center for Health and Aging, San Francisco, CA 94143.

Investigator: Robert Newcomer, Ph.D.

The social health maintenance organization (S/HMO) seeks to enroll, voluntarily, persons 65 years of age or over in an innovative prepaid program that integrates medical, social, and long-term care delivery systems. The S/HMO merges the health maintenance organization concepts of capitation financing and provider risk sharing developed by the Health Care Financing Administration (HCFA) under its Medicare

capitation and competition demonstrations with the case management and support services concepts underlying the Department of Health and Human Services (DHHS)-sponsored long-term care demonstrations serving the chronically ill aged.

This contract was awarded in September 1985. An interim report was forwarded to Congress in August 1988. A copy of the report, evaluation of the Social/Health Maintenance Organization Demonstration, may be obtained from the National Technical Information Service (NTIS), accession number PB89-215446. The evaluation and data collection plan for the demonstration is available from NTIS as a technical appendix and may be obtained by using accession number PB89-191779. The data collection phase has been completed. Data analysis will be completed in fall 1991.

Preliminary findings regarding biased selection in enrollment and case management were presented at the 1990 American Public Health Association Annual meeting.

Suitability of Grade of Membership Techniques to Correct for Selection Bias in the Social Health Maintenance Organization Evaluation

Period: March 1991-June 1991.

Total Funding: \$2,500.

Contractor: Division of Health Services Research and Policy, School of Public Health, University of Minnesota, 420 Delaware St. SW., Box 729, Minneapolis MN 55455.

Investigator: Roger D. Feldman, Ph.D.

The purpose of this project is to provide technical advise in assessing the suitability of grade of membership (GoM) analysis to correct for selection bias in the social/health maintenance organization demonstration evaluation.

This project is complete and a final report has been received. The researchers concluded that while GoM is an innovative and useful method of data reduction, it does not correct for selection bias in the S/HMO evaluation analyses. They further recommend that the effects of selection bias be tested for and, if feasible, corrected in the evaluation analyses.

Design of the Second General Social/Health Maintenance Organization

Period: July 1991-February 1992.

Total Funding: \$285,660.

Awardee: Brandeis University Research Center, 415 South St., Waltham, MA 02254.

Investigator: Stuart Altman, Ph.D.

Section 4207(b)(4) of Public Law 101-508 requires approval of not more than four additional social/health maintenance organization (S/HMO) sites. The purpose of these second generation S/HMO sites is to refine the targeting and financing methodologies and benefit design of a S/HMO. This study is to analyze design issues (includes recommendations) associated with the development of one or more models of the second generation S/HMOs.

This project is in the early stages of development.

Study of the Second Generation Social/Health Maintenance Organization (S/HMO)

Period: July 1991-March 1992.

Total Funding: \$100,000.

Awardee: University of Minnesota Research Center, 1919 University Ave., St. Paul, MN 55104.

Investigator: Michael Finch, Ph.D., Rosalie Kane, D.S.W.

In accordance with the congressional mandate (section 2355, Pub. L. 98-369, as amended), the concept of a social/health maintenance organization (S/HMO) for acute and long-term care is being implemented. The purpose of this project is to conduct an analysis of the conditions and consideration related to participation in a S/HMO by providers, insurers, consumers, and State Medicaid agencies.

This project is in the early stages of development.

Analysis of Implementation Issues Related to a Capitated Acute and Long-Term Care Service Delivery System

Period: August 1991-July 1992.

Total Funding: \$99,822.

Awardee: Brandeis University Research Center, 415 South St., Waltham, MA 02254.

Investigator: Walter Leutz, Ph.D.

The purpose of this project is to analyze issues related to marketing strategies, reimbursement rates and mechanisms, site selection criteria, and site operational protocols for a capitated acute and long-term care service delivery system.

This project is in the early stages of development.

Demonstration of Medicare Payment for Community Nursing Organizations

Period: August 1988-September 1991.

Total Funding: \$326,409.

Awardee: Project Hope Research Center, Two Wisconsin Circle, Suite 500, Chevy Chase, MD 20815.

Investigator: Robin Stone, Ph.D.

The purpose of this project is to assist the Health Care Financing Administration in designing a demonstration project (consisting of at least four sites) to provide payment to community nursing organizations (CNOs) for home health services, durable medical equipment, and certain ambulatory care furnished to Medicare beneficiaries on a prepaid, capitated basis. Public Law 100-203 specifies that two different capitated payment methods must be implemented in the demonstration. Before the implementation of the demonstration, detailed planning and development of the project design elements required of the congressional mandate must be undertaken. These include:

- Establishing organizational requirements and standards for CNOs.
- Developing a detailed methodology for computing payment rates.
- Preparing an implementation plan for the demonstration which includes developing site selection criteria, quality assurance mechanisms and marketing strategies appropriate for the sites, criteria for evaluating site proposals, and selecting demonstration sites, and an evaluation strategy.

The basic elements of the demonstration design have been completed. A Request for Proposal to develop demonstration sites was issued in late 1991 and contracts to the project sites scheduled are to be awarded in April 1992.

Implementation of Home Health Agency Prospective Payment Demonstration

Period: June 1990-June 1995.

Total Funding: \$1,629,606.

Contractor: Abt Associates, Inc., 55 Wheeler St. Cambridge, MA 02138.

Investigator: Henry Goldberg.

This contract involves implementation and monitoring of a demonstration testing alternative methods of paying home health agencies (HHAs) on a prospective basis for services furnished under the Medicare program. This demonstration will test 2 prospective payment approaches—payments per visit by type of discipline and payments per episode of Medicare-covered home health care.

In June 1990, Abt Associates began recruiting HHAs to participate in the demonstration's first phase. This phase involving the per visit payment method began operation on October 1, 1990. Recruitment of HHAs to voluntarily participate in this phase will continue through September 30, 1991. HHAs that agree to participate enter the demonstration at the beginning of their next fiscal year. Approximately 50 HHAs have agreed to participate in Phase I. Further development work on the per episode payment method is being carried out in 1991, and implementation of the second phase testing the per episode payment method is scheduled to begin in 1992. The study design calls for recruiting of an additional 66 HHAs to participate in Phase II beginning in early 1993. In each phase, HHAs that agree to participate are randomly assigned to either the prospective payment method or to a control group that continues to be reimbursed in accordance with the Medicare current retrospective cost system. Each HHA will participate in the demonstration for 3 years.

Evaluation of the Home Health Prospective Payment Demonstration

Period: September 1990-September 1995.

Total Funding: \$2,858,676.

Contractor: Mathematica Policy Research, Inc., Box 2393, Princeton, NJ 08543.

Investigator: Barbara Phillips, Ph.D.

The purpose of this contract is to evaluate the first phase of a demonstration designed to test the effectiveness of using prospective payment methods to reimburse Medicare-certified home health agencies (HHAs) for services provided under the Medicare program. In Phase I, a per visit payment method which sets a separate payment rate for each of six types of home health visits (i.e., skilled nursing, home aide, physical therapy, occupational therapy, speech therapy, and medical social services) will be tested. Mathematica Policy Research will evaluate the effects of this payment method on HHAs' operations, quality of services HHAs deliver to Medicare beneficiaries, and Medicare expenditures. The contractor will also analyze

the relationship between patient characteristics and the cost and use of HHA services in order to develop improved methodologies for adjusting prospective payment rates for case-mix variations.

The demonstration began on October 1, 1990. The contractor has submitted a design report, information collection clearance packages, and several quarterly reports. The contractor is currently conducting case studies and case-mix analyses, as well as other analyses of HHA costs and services use patterns, to assist HCFA in refining the per-episode payment method that will be tested in Phase II of this demonstration.

A special report on the results of the contractor's case-mix analyses is due to HCFA in April 1992. Phase II of the demonstration, which will test the per episode payment method, is scheduled to begin in early 1993.

FUTURE DIRECTIONS FOR LONG-TERM CARE

During 1991, HCFA devoted substantial resources to the further development and implementation of demonstrations to test the cost-effectiveness of prospective payment systems for nursing homes and home health agencies implement and monitor new coordinated care systems for the frail elderly, and develop outcome-oriented quality measures to improve the quality of care in these settings.

We will continue to test alternative financing schemes for long term care services, including preparations for implementation of the Multi-State Nursing Home Case Mix and Quality Demonstration. The Home Health Agency Prospective Payment Demonstration will continue during 1992, and we will continue current analyses to develop a case-mix adjusted per-episode payment methodology to be implemented in the second phase of the demonstration. Development activities related to the Community Nursing Organization Demonstration will continue, include the selection of demonstration sites and an evaluation contractor.

We will continue our efforts to develop, operate, and evaluate coordinate care systems for the frail elderly, including the Medicare Alzheimer's Disease Demonstration, the Program for the All-inclusive Care of the Elderly Demonstration, and the Social/Health Maintenance Organization Demonstration.

We also will continue the development and testing of outcome-oriented measures of quality for nursing home and home health services and assessment of the applicability of using payment generated data to monitor quality. In this light, we will continue to develop a multi-State demonstration integrating resident assessment and case-mix payment data with the quality assurance process for nursing home providers.

Another very important area that will continue to be explored is alternative financing mechanisms for long-term care. Although the majority of the elderly are covered by both Medicare and supplemental insurance, a large portion of long-term care services remain uncovered. Medicaid covers long-term nursing care, but only after the elderly individuals have depleted their resources. Research is continuing that will identify the sources of financing for long-term care at various points throughout institutionalization. This research will further examine characteristics of individuals who come to rely upon Medicaid for payment for their care. By identifying the risks associated with nursing home use, we hope to be able to propose improved methods of paying for this care. Alternatives being studied as a solution for some of the elderly's problems in financing long-term care are life care centers and private long-term insurance. Other ORD financing research continues to examine various States' reimbursement of long-term care in order to assess the feasibility of recommending policy changes, e.g., prospective payment for SNF care.

We will continue to support data collection and data analyses from projects that gather detailed information from representative national samples or other large segments of the elderly population. Research is continuing on the estimated future acute and long-term care utilization based on information from available surveys on the morbidity, disability, and mortality of different birth cohorts. We will continue initiatives to make additional data bases available for research and analysis, such as the 1989 Long-Term Care Survey and State Medicaid data.

ADMINISTRATION FOR CHILDREN AND FAMILIES

TITLE XX SOCIAL SERVICE BLOCK GRANT PROGRAM

The major source of Federal funding for social services programs in the States is Title XX of the Social Security Act, the Social Service Block Grant (SSBG) program. The Omnibus Budget Reconciliation Act of 1981 (P.L. 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 eligible jurisdictions (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. Public Law 97-35 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.

Under the SSBG, Federal funds are available without a matching requirement. In fiscal year 1991, a total of \$2.8 billion was allotted to States. The same amount has been appropriated for fiscal year 1992. 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, chore 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.

Based on an analysis of pre-expenditure reports submitted by the States for fiscal year 1990, 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	46
Adult Protective Services	30
Transportation Services	25
Adult Day Care	26
Health Related Services	23
Information and Referral	25
Home Delivered/Congregate Meals	20
Adult Foster Care	10
Housing	16

¹ Includes 50 States, the District of Columbia, and the five eligible territories and insular areas.

² Includes homemaker, chore, home health, companionship, and home maintenance services.

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.

As reflected above, 30 States currently provide Adult Protective Services to persons generally 60 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 also 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 one of six block grant programs administered within the Department of Health and Human Services (HHS). LIHEAP is administered by the Office of Community Services (OCS) in the Administration for Children and Families.

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 Augustus F. Hawkins Human Services Reauthorization Act of 1990. In fiscal year 1989 Congress appropriated \$1,383 billion for the program. Congress appropriated \$1,443 billion for LIHEAP in fiscal year 1990. In fiscal year 1991, Congress appropriated \$1.415 billion plus a contingency fund of \$195 million which went into effect when fuel oil prices went above a certain level. For FY 1992, \$1.5 billion has been appropriated, plus a contingency fund of \$300 million that will be triggered if the President declares an emergency and requests the funds from Congress.

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 Aid to Families with Dependent Children, 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 1991, about 39 percent of households receiving assistance with heating costs included at least one person age 60 or over, as estimated by the March 1991 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.

No major program and policy changes for the elderly occurred in the 1990 reauthorization legislation. No new initiatives commenced in 1991 or are planned for 1992 that would impact on the status of older Americans.

THE COMMUNITY SERVICES BLOCK GRANT (CSBG) AND THE ELDERLY

I. Community Service Block Grant—The Community Service Block Grant Act (Subtitle B, Public Law 97-35 as amended) is authorized through fiscal year 1994. The Act authorizes the Secretary, through the Office of Community Services (OCS), an office within the Administration for Children and Families in the Department of Health and Human Services, to make grants to States and Indian tribes or tribal organizations. States and tribes have the authority and the flexibility to make decisions about the kinds of local projects to be supported by the State or tribe, using CSBG funds. The purposes of the CSBG program are:

(A) to provide a range of services and activities having a measurable and potentially major impact on causes of poverty in the community or those areas of the community where poverty is a particularly acute problem.

(B) to provide activities designed to assist low income participants including the elderly poor—

- (i) to secure and retain meaningful employment;
- (ii) to attain an adequate education;
- (iii) to make better use of available income;
- (iv) to obtain and maintain adequate housing and a suitable living environment;
- (v) to obtain emergency assistance through loans or grants to meet immediate and urgent individual and family needs, including the need for health services, nutritious food, housing, and employment-related assistance;

³ Beginning with fiscal year 1986, States are prohibited from setting income eligibility levels lower than 110 percent of the poverty level.

(vi) to remove obstacles and solve problems which block the achievement of self-sufficiency;

(vii) to achieve greater participation in the affairs of the community; and

(viii) to make more effective use of other programs related to the purposes of the subtitle,

(C) to provide on an emergency basis for the provision of such supplies and services, nutritious foodstuffs and related services, as may be necessary to counteract conditions of starvation and malnutrition among the poor;

(D) to coordinate and establish linkages between governmental and other social services programs to assure the effective delivery of such services to low income individuals; and

(E) to encourage the use of entities in the private sector of the community in efforts to ameliorate poverty in the community; (Reference Section 675(c)(1) of Public Law 97-35, as amended).

It should be noted that although there is a specific reference to "elderly poor" in (B) above, there is no requirement that the States or tribes place emphasis on the elderly or set aside funds to be specifically targeted on the elderly. Neither the statute nor implementing regulations include a requirement that grant recipients report on the kinds of activities paid for from CSBG funds or the types of indigent clients served. Hence, it is not possible for OCS to provide complete information on the amount of CSBG funds spent on the elderly, or the number of elderly, or the numbers of elderly persons served.

II. Major Activities or Research Projects Related to Older Citizens in 1991 and 1992—The Office of Community Services made no major changes in program or policy related to the CSBG program in 1991 and none is planned for 1992.

The Human Services Reauthorization Act of 1986 contained the following language: "each such evaluation shall include identifying the impact that assistance . . . has on . . . the elderly poor."

The collection of impact data activity required by this language began in fiscal year 1991 and will be available in the fall of 1992.

III. Funding Levels—Funding levels under the CSBG program for States and Indian tribes or tribal organizations amounted to \$349,367,458 in fiscal year 1991. In fiscal year 1992, \$360,000,000 has been appropriated.

AGING AND DEVELOPMENTAL DISABILITIES PROGRAM

CRITICAL AUDIENCES PROJECT

Grantee: Institute for the Study of Developmental Disabilities, Indiana University
Project Director: Barbara Hawkins, Re.D.-(812) 855-6506; Fax (812) 855-9630
Project Period: 7/1/90-6/30/93, FY '90-\$90,000, FY '91-\$90,000, FY '92-\$90,000, FY '93-\$90,000

The project provides training in a late-life functional-developmental model for audiences that are critical to effective planning and care of older persons. Activities include developing training modules and instructional videos for interdisciplinary university credit courses, and illustrating the model by demonstration projects in community retirement settings.

CENTER ON AGING AND DEVELOPMENTAL DISABILITIES (CADD)

Grantee: University of Miami/CADD, Miami, FL
Project Director: John Stokesberry, Ph.D.-(305) 325-1043
Project Period: 7/1/90-6/30/93, FY '90-\$90,000, FY '91-\$90,000, FY '92-\$90,000, FY '93-\$90,000

CADD is providing education and training to service providers, parents and families; advocacy and outreach for consumers, information to the public on aging and developmental disabilities; networking, policy direction and community-based research. Materials will include a manual for parents/caregivers, a resource guide and a handbook on developing a peer companion project.

INTERDISCIPLINARY TRAINING CENTER

Grantee: UAP-Institute for Human Development, University of Missouri-Kansas City

Project Director: Gerald J. Cohen, J.D., M.P.A.-(816) 235-1770; Fax (816) 235-1762
Project Period: 7/1/90-6/30/93, FY '91-\$90,000, FY '92-\$90,000, FY '93-\$90,000

The Center addresses personnel preparation needs with a focus on administration, interdisciplinary training, exemplary services, information/technical assistance/research; and evaluation. Materials include training guide for aging, infusion models,

inservice fellowship curriculum, resource bibliography, guide for training volunteers, and course syllabus.

TRAINING MODELS FOR RURAL AREAS

Grantee: Montana University Affiliated Rural Institute on Disabilities, Missoula, MT

Project Director: Philip Wittekiend, M.S. (406) 243-5467; Fax (406) 243-2349

Project Period: 7/1/90-6/30/93, FY '90-\$90,000, FY '91-\$90,000, FY '92-\$90,000, FY '93-\$90,000

Montana's focus is on linking existing networks and expertise to meet the unique needs of a rural area with sparse populations and limited professional resources. The project will develop audio conference packages with simultaneous long distance training for remote areas and involve nontraditional networks such as churches and senior groups.

CONSORTIUM OF EDUCATIONAL RESOURCES

Grantee: UAP-University of Rochester Medical Center, Rochester, NY

Project Director: Jenny C. Overeynder, ACSW (716) 275-2986; Fax (716) 256-2009

Project Period: 7/1/90-6/30/93, FY '90-\$90,000, FY '91-\$90,000, FY '92-\$90,000, FY '93-\$90,000

An inter-university interdisciplinary consortium of educational resources in gerontology and developmental disabilities is being established in western New York, to be linked to local and state networks. The project will develop and implement preservice and inservice education curriculum for direct care and nursing home staff.

AGING AND DEVELOPMENTAL DISABILITIES CLINICAL ASSESSMENT, TRAINING AND SERVICE

Grantee: Waisman Center UAP, University of Wisconsin-Madison

Project Director: Gary B. Seltzer, Ph.D.-(608) 263-1472; Fax (608) 263-0529

Project Period: 7/1/90-6/30/93, FY '90-\$90,000, FY '91-\$90,000, FY '92-\$90,000, FY '93-\$90,000

Waisman Center operates an interdisciplinary clinic, provides training to health care and other professionals, and disseminates information and technical assistance to director care networks. Materials include a functional assessment instrument and curricula for medical students, geriatric fellows and physician assistants.

INTERDISCIPLINARY TRAINING MODELS (IDT)

Grantee: UAP, College of Family and Consumer and Consumer Sciences

Project Director: Zolinda Stoneman, Ph.D., (404) 542-4827; Fax (404) 542-4815

Project Period: 7/1/90-6/30/93, FY '91-\$90,000, FY '92-\$90,000, FY '93-\$90,000

This project is using IDT models for graduate and undergraduate training; developing community-based internship and practicum sites; collecting audiovisual materials for dissemination; and providing information to the UAP regional information and referral service. Products will include training videotapes and modules, course materials, and radio program recordings.

COMMUNITY INTEGRATION PROJECT IN AGING AND DEVELOPMENTAL DISABILITIES (CIPADD)

Grantee: NYS Office of Mental Retardation/DD, Albany, NY

Project Director: Matthew P. Janicki, Ph.D. (518) 473-7855; Fax (518) 486-6714

Project Period: FY '91-\$147,255, FY '92-\$147,255 CIPADD is a cooperative effort of the New York State DD Planning Council, State Office for the Aging, State Office of Mental Retardation and DD, University of Rochester University Affiliated Program for Developmental Disabilities (UAPDD) Training Program in Aging and DD, Hunter College Brookdale Center on Aging, Institute of Gerontology at Utica College, and Rome DD Services Office. Products and activities include a how-to manual, case monographs on model projects, workshops demonstrating step-by-step approaches to promoting integration and a program manual.

MISSOURI DEVELOPMENTAL DISABILITIES AND ELDERLY RESOURCE NETWORK (MODERN)

Grantee: UAP-Institute for Human Development Missouri, MO Developmental Disabilities and Elderly Resource Network (MODERN) Project Director: Gerald J. Cohen, J.D., M.P.A.

Project Period: FY '91-\$142,160, FY '92-\$142,160 MODERN is a collaborative effort of the University of Missouri in Kansas City's Institute for Human Develop-

ment through its Interdisciplinary Training Center on Gerontology and DD, Missouri Planning Council for DD, Missouri Protection and Advocacy Services, Missouri Division of Mental Retardation/DD, Missouri Association of County Developmental Disability Services, and local interagency groups from St. Louis, Clay/Platte and Central Missouri. Products and activities include development of a centralized resource center with an 800 number, creation of an interagency Task Force to address policy and procedural concerns, dissemination of models and strategies, cross-training of case managers, and support for local interagency work groups.

PARTNERS II: IMPROVING SERVICES TO OLDER PERSONS WITH DD-POLICY TRAINING AND SERVICE

Grantee: Virginia Institute for DD Virginia Commonwealth University, Richmond, VA

Project Director: Joan Wood, Ph.D. (804) 786-8903; Fax (804) 371-7905

Project Period: 7/1/90-6/30/93 FY '91-\$90,000, FY '90-\$90,000, FY '92-\$90,000, FY '93-\$90,000

Project partners are Virginia Department of Aging, Board of Rights of Virginians with Disabilities, Virginia Center on Aging and Virginia Center on Aging and Virginia Institute on DD at Virginia Commonwealth University, Rappahannock-Rapidan Community Services Center, Norfolk Senior Center, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, SEVAMP Area Agency on Aging. Products and activities include recommendations for public policy, personnel training, staff exchange, national teleconference, resource directories, community resource fairs, and strategies for identifying persons at risk for institutionalization.

LIFE LONG PLANNING: DEVELOPING STATE AND LOCAL PLANNING LINKAGES TO IMPROVE OPPORTUNITIES FOR OLDER PERSONS WITH DEVELOPMENTAL DISABILITIES

Grantee: Program on Aging and Developmental Disabilities, Madison, WI

Project Director: Marilyn Wilson, (608) 263-0815

Project Period: FY '90-\$135,000, FY '91-\$135,000, FY 92-\$135,000

A cooperative effort of Bureau on Aging, Developmental Disabilities Office, Waisman Center at the University of Wisconsin-Madison, Wisconsin Council on Developmental Disabilities, and the Wisconsin Coalition for Advocacy, the grant focuses on a rural and an urban county and on Wisconsin's older Native Americans who have developmental disabilities. Products and activities include a series of personal futures planning and circles of support, local and statewide planning efforts, monographs and articles for aging and developmental disability-related newsletter.

INTERDISCIPLINARY TRAINING MODELS (IDT)

Grantee: UAP, College of Family and Consumer and Consumer Sciences

Project Director: Zolinda Stoneman, Ph.D., (404) 542-4827; Fax (404) 542-4815

Project Period: 7/1/90-6/30/93, FY '90-\$90,000, FY '91-\$90,000, FY '92-\$90,000, FY '93-\$90,000

This project is using IDT models for graduate and undergraduate training; developing community-based internship and practicum sites; collecting audiovisual materials for dissemination; and providing information to the UAP regional information and referral service. Products will include training videotapes and modules, course materials, and radio program recordings.

ADMINISTRATION ON AGING

DEVELOPMENTS IN AGING FISCAL YEAR 1991

INTRODUCTION

This report describes the major activities of the Administration on Aging (AoA) in Fiscal Year 1991. Title II of the Older Americans Act of 1965 (the Act) established the Administration on Aging as the principal Federal agency for carrying out the provisions of the Act. The 1987 Amendments to the Act reaffirmed the responsibilities of AoA, State Agencies, and Area Agencies to assure that provisions for serving older people are established, strengthened, and extended throughout the Nation. Through the amendments, Congress also reaffirmed the need for strong partnerships with and on behalf of older people. Congressional action also underscored concern for the most vulnerable elderly and emphasized the need to assure that priority is given to strengthening community level services on their behalf.

The Older Americans Act seeks to remove barriers to economic and personal independence for older persons and to assure the availability of appropriate services for those older persons in the greatest social or economic need. The provisions of the Act are implemented primarily through a national "network on aging" consisting of the Administration on Aging at the Federal level, State and Area Agencies on Aging established under Title III of the Act, and the agencies and organizations providing direct services at the community level. In FY 1991, Congress appropriated \$792,510,000 to support programs and activities to implement the provisions of the Act, which are administered by AoA. This excludes \$181,000 available for the Federal Council on the Aging under the Older Americans Act appropriation and \$976,000 for the White House Conference on Aging.

This report is divided into four sections. Section I describes AoA's roles and functions. It highlights various activities undertaken by AoA; in particular, the National Eldercare Campaign which is a multiyear, nationwide effort to mobilize resources for older persons at risk of losing their independence. The National Eldercare Campaign was developed in partnership with public and private agencies, other Federal and national organizations such as the National Association of State Units on Aging and the National Association of Area Agencies on Aging. Section II provides an overview of the provisions of Title III of the Older Americans Act. It summarizes the principal activities of the network of State and Area Agencies on Aging in FY 1991. Section III describes the Title VI program of grants to Indian tribal organizations and Native Hawaiians and the efforts of the Administration on Aging in assessing outreach to older Native Americans. Section IV presents a summary of AoA's FY 1991 discretionary activities under Title IV, and a description of the FY 1991 special activities and initiatives conducted by AoA in support of the National Eldercare Campaign.

SECTION I—THE ADMINISTRATION ON AGING

ROLE AND FUNCTION OF AoA

The Administration on Aging (AoA) is located in the Office of the Secretary of the Department of Health and Human Services (HHS). The agency is headed by the U.S. Commissioner on Aging, who is appointed by the President with confirmation by the Senate and who reports directly to the Secretary. Joyce T. Berry, Ph.D., was appointed Acting Commissioner on Aging in April 1989. She was subsequently nominated by President Bush and unanimously approved by the Senate. She was sworn in as U.S. Commissioner on Aging in March 1990.

AoA programs are administered through a Central Office located in Washington, D.C. and 10 Regional Offices. Title II of the Older Americans Act, as amended, describes the basic roles and functions of AoA. Chief among these are to serve as an effective and visible advocate for older persons (including American Indians, Alaskan Natives, and Native Hawaiians) within the Department and with other agencies and organizations at the national level and to administer the programs authorized by Congress under Titles III, IV, and VI of the Act.

The U.S. Commissioner on Aging provides policy advice to the Secretary of Health and Human Services in matters affecting older Americans and information to other Federal agencies and to Congress on the characteristics, circumstances and needs of older persons. The Administration on Aging reviews and comments on departmental policies and regulations concerning services which affect the health and general well-being of older persons.

ELDERCARE: CHALLENGE FOR THE 1990s AND BEYOND

Demographic trends underscore the burgeoning numbers and the importance of our older population. By the year 2030, one of every four Americans, over 83 million persons, will be 60 years or older and approximately 8 million of them will be age 85 or older. What has been called the "graying of America" has captured considerable media attention and given rise to widespread concern over future economic, political, and societal trends, especially when the baby-boom generation reaches age 60+ in the early decades of the 21st century.

It is crucial that we, as a nation, build our capacity to respond to the dramatic increase in our older population today and into the next century. That challenge is heightened by the growing numbers of elderly who are at risk, including those who are physically or mentally impaired; abused, neglected, or exploited; or without a caregiver to assist them when in need. At special risk are those older people who are poor; particularly women, rural Americans, and members of minority groups. For these older Americans the term "eldercare" has a special meaning. It defines

for our society a caregiving role aimed at helping vulnerable persons to function independently at home and in the community as long as possible. Eldercare embodies a culture of caring for our families, our parents, our neighbors, and our friends.

B. THE NATIONAL ELDERCARE CAMPAIGN—CURRENT EMPHASES AND ACTIVITIES

In the past year, under the leadership of the U.S. Commissioner on Aging, Joyce T. Berry, Ph.D., the Administration on Aging has committed its program, staff, and leadership resources to a National Eldercare Campaign—a nationwide, multiyear effort aimed at providing services and opportunities for older persons at risk of losing their self-sufficiency. The Eldercare Campaign is based on the realization that the needs of our rapidly growing older population, and the special challenges presented by millions of at-risk elderly, have and will continue to out-strip available public resources. Strong and purposeful coalitions, representing all segments of society with a stake in our Nation's future, must be mobilized for action and advocacy at all levels, but especially in our communities.

During its early critical stages, the Eldercare Campaign has been solidly based on three components:

(1) *Building Public Awareness*—A national public awareness strategy is being directed toward making all segments of society aware of the implications of an aging society and of the growing urgency in responding to the risks faced by the most vulnerable segments of our older population;

(2) *Expanded Organizational Involvement*—Under this second component of the National Eldercare Campaign, AoA is reaching out to and working with traditional aging organizations as well as nontraditional organizations representing government, business, the professions, and the voluntary, religious, educational, and other interested communities, to gain their commitment to an Eldercare agenda of serving vulnerable older persons; and

(3) *Community Eldercare Coalition Building*—Project CARE Community Action to Reach the Elderly) coalitions have been established in almost 300 communities to organize and focus their attention on one primary concern of at-risk older persons, and to combine resources as part of a coordinated response to the identified need.

To assist in carrying out these components of the National Eldercare Campaign, the Administration on Aging in FY 1991 made a number of Title IV project awards to agencies and organizations competing under the National Eldercare Institutes, the Discretionary Funds Program, and other program announcements. These program activities include the following which are described in full detail in Section IV of this report:

1. NATIONAL ORGANIZATIONS

In 1991, AoA Central and Regional Office staff began a series of contacts with selected associations and organizations outside the traditional aging network, to gain their commitment and participation in aging issues and the Eldercare Campaign. These outreach efforts have resulted in a number of agencies and organizations becoming involved in a substantial and significant way in the Eldercare effort. AoA is now working with these organizations toward developing substantive program initiatives and designing strategies for incorporating these initiatives as an integral part of community based services and opportunities.

In a further effort to expand organizational involvement in the National Eldercare Campaign, AoA made awards under its FY 1991 Discretionary Funds Program to:

(a) seven national aging organizations to stimulate new initiatives for addressing home and community based care needs of older persons at risk and to expand public awareness relating to the problems and issues of eldercare; and

(b) eleven national (non-aging) organizations for promoting awareness among their affiliates and members of the necessity for immediate and substantive action in preparing for an aging society and integration of eldercare into their ongoing agendas.

2. OLDER AMERICANS ACT ELDERCARE VOLUNTEER CORPS

Volunteers have long been the backbone of Older Americans Act service systems since 1965. Through the Eldercare Volunteer Corps initiative, AoA recognizes the more than half a million volunteers who serve in Older Americans Act programs. Twenty-eight States received FY 1991 Title IV Discretionary Grant Funds to develop and demonstrate improved methods for recruiting, training, and retaining volunteers as part of a volunteer management program.

3. PROJECT CARE

Project CARE was launched in May 1991 for the development of a multi-year program to promote community action on behalf of the at risk elderly in danger of losing their independence. Project CARE Coalitions are being established in nearly 300 communities nationwide to identify a problem of primary importance to the vulnerable elderly, and then to develop a community coalition of partners to advocate and develop new and innovative approaches in mobilizing resources to respond to the need.

Each State Agency on Aging, through its Area Agencies, will establish at least three Project CARE communities to expand home and community based services. In addition, under the 1991 Discretionary Grant Announcement, AoA has funded 16 Area Agencies to develop three Project CARE Coalitions in three different communities within the Planning and Service Area covered by the Area Agency. Phase II of these latter projects calls for replication of the coalition building in three more communities within the planning and service area.

4. NATIONAL ELDERCARE INSTITUTES

In September, grant awards were made by AoA to support 12 National Eldercare Institutes, each focused on a substantive issue area critical to the improvement of eldercare services. The Institutes will work with community eldercare coalitions to strengthen the capacity of these coalitions to respond knowledgeably to issues concerning the development and implementation of in-home and community-based eldercare services and opportunities. They will, in addition, provide guidance and expertise to national aging and non-aging organizations, across the public, private, and voluntary sectors, for achieving the objectives of the eldercare campaign. In carrying out these responsibilities, the Institutes will undertake certain core functions: knowledge synthesis and analysis; the dissemination of useful information and materials; and a range of training, consultative, and technical assistance activities.

MEDIA CONTRACT AND SUPPORT CONTRACT

To assist in gaining greater public awareness and alert the public to the need for collective action in meeting the challenges of an aging population, AoA awarded a media contract to Global Exchange Inc. of Chevy Chase, MD. This contractor will develop and implement a work plan for communicating the goals and objectives of the Eldercare Campaign, conveying information to target audiences, and helping AoA with the public awareness aspects of the Campaign. Global Exchange, an organization with extensive experience in social issue public awareness, will assist AoA in publishing a newsletter, development of public information packages, and other materials.

Emprise Designs, Inc. of St. Louis, MO, will support AoA's management and coordination of the National Eldercare Campaign through (1) training and technical assistance to Project Care communities in coalition building; (2) conference and symposia logistics on various subject matter areas impacting on the at-risk elderly; and (3) collection, analysis, preparation, and dissemination of reports, calendars, newsletters, and information packets for the various Eldercare Campaign components.

Thus substantial progress is now being made under the National Eldercare Campaign toward directing public attention and focusing organizational agendas as well as community coalitions on the needs of at-risk older persons. But much more interest needs to be generated, much more needs to be done by and on behalf of those elderly who are near or at the brink of losing their independence.

BUSINESS AND AGING

AoA is reaching out to the business community to encourage them to make a commitment to aging concerns both as employers and community citizens. In addition to the following initiatives, the Commissioner and AoA staff have made numerous presentations to business representatives on an individual basis and in public forums sponsored by national associations and industries.

BUSINESS AND AGING LEADERSHIP AWARDS

In order to reward companies that have made a commitment to aging issues and to highlight exemplary programs, AoA established a Business and Aging Leadership Awards Programs. Over 165 companies were nominated for initiatives they had undertaken in four categories: Employment & Training, Work/Family Issues, Health Promotion, and Volunteerism/Community Initiatives. In a May 1991 ceremony,

Commissioner Berry and Secretary Sullivan presented awards to 23 companies in recognition of their accomplishments.

PRIVATE SECTOR MANAGEMENT COMMITTEE

In 1990, AoA sought to increase the involvement of a newly established Private Sector Management Committee, comprised of approximately 20 key management officials from selected business organizations and industries. The Committee advises AoA on issues that confront the business community as it deals with an aging America.

AMERICAN EXPRESS

AoA and American Express have undertaken a joint initiative to develop a model public/private sector corporate eldercare program. Through this two year initiative the Area Agencies on Aging in Fort Lauderdale and Jacksonville, FL are working with their local American Express offices on the development of an eldercare program for American Express employees. It is anticipated that the program will be replicated in other communities in the nation.

FOUNDATION ROUNDTABLE

AoA has begun to work with the foundation community, including a number of corporate foundations. In April 1991, the Commissioner convened a roundtable of executives from approximately 35 foundations. The roundtable provided for an exchange of ideas and an opportunity to encourage foundation involvement in aging issues and the National Eldercare Campaign.

FEDERAL INTERDEPARTMENTAL TASK FORCE ON AGING

At the national level, AoA's leadership role places major emphasis on developing collaborative relationships with other Federal agencies to facilitate the development of methods to achieve a coordinated response to the needs, problems, and concerns of older persons. In this regard, AoA established the Federal Interdepartmental Task Force on Aging and convened the first meeting on June 20, 1990. The Primary mission of the Task Force is to develop issues for policy and program coordination and to develop collaborative interdepartmental approaches in preparation for the changing and growing elderly population. The Task Force is comprised of representatives from the Department of Agriculture, Department of Education, Department of Energy, Department of Justice, Department of Labor, Department of Housing and Urban Development, Department of Transportation, Department of Veterans Affairs, ACTION, Family Support Administration, Federal Council on Aging, Health Care Financing Administration, Health Resources and Services Administration, National Institute on Aging, and Social Security Administration. The Task Force established four work groups, Housing, Employment/Volunteers, Health, and In-Home and Community-Based Care Services. The work group has convened meetings to identify and select issues of major concern in the designated subject areas, prioritized issues, develop action plans and report recommendations to the Task Force. In addition to the recommendations, the Task Force plans to address issues related to the National Eldercare Campaign, Elder Abuse and the 1993 White House Conference on Aging.

HOUSING

AoA continued its efforts to strengthen linkages with other agencies which have responsibility for elderly housing. Working in conjunction with the Department of Housing and Urban Development (HUD), an information memorandum was prepared and sent to all State and Area Agencies on Aging summarizing the elderly housing provisions of Title VIII of the National Affordable Housing Act. AoA staff served on two HUD Task Forces developing the implementing regulations for the revised Congregate Housing Services Program and HOPE for Elderly Independence program.

AoA regional staff participated in two HUD regionally sponsored conferences to increase staff expertise regarding elderly housing and strengthen interagency effort at the regional level.

AoA also pursued discussions with HUD related to problems caused by the housing of physically and mentally handicapped younger persons in elderly housing.

Under an AoA-HUD Interagency agreement several training sessions were held around the country during the last 2 years to train housing counselors, aging staff and legal aids who serve the elderly under the Federal reverse mortgage insurance

demonstration program. Under the program, HUD has authority to insure up to 25,000 home equity conversion loans for elderly homeowners.

A Memorandum of Understanding (MOU) was signed between the Farmers Home Administration (FmHA) and the Administration on Aging. The purpose of the MOU is to support joint efforts by the agencies to improve coordination of programs which relate to the rural housing needs of older persons. The agreement sets up a framework under which both agencies can work to improve the coordination of programs funded under their respective legislative authorities, increase public awareness of FmHA programs, particularly congregate housing and the nutrition and supportive services programs of AoA, and encourage the replication of interagency agreements between FmHA State Offices and the State Agencies on Aging. Working with subgroups from the Federal Interagency Task Force, a number of issues were identified related to elderly housing. These issues will be considered for further discussion with the full Task Force.

EMPLOYMENT

Regional Offices in cooperation with the Department of Labor have sponsored employment and training conferences which target Older Worker employment opportunities, placement, and retention.

AoA has funded various types of research and demonstration projects which have developed training materials and techniques to improve and enhance employment opportunities for Older Workers.

Through the funding of dissemination projects, AoA has targeted employers and potential employers to receive information on the abilities of older workers and dispel myths related to aging which projects a negative image of the older worker.

AoA has funded an National Eldercare Institute on Employment and Volunteerism which will be located at the University of Maryland, Center on Aging.

TRANSPORTATION

The Administration on Aging has awarded a National Eldercare Institute on Transportation cooperative agreement to the Community Transportation Association of America. The National Eldercare Institute on Transportation will be discussed under Title IV program section of this Report.

Under an agreement with the Urban Mass Transportation Administration, U.S. Department of Transportation, AoA and UMTA jointly funded a Volunteer Van Transportation Program. A grant was awarded to the Chickasaw Nation of Oklahoma to develop a volunteer van transportation program. The Volunteer Van Transportation Program will demonstrate the use of a partnership between the Federal Government and a community-based Native American Indian Nation to develop and maintain a transportation program to improve the coordination of transportation services for low incomes, frail, disabled, homebound elderly, nonaffiliated and affiliated Tribal Native Americans and rural Native Americans. The transportation services will provide access to nutrition, health, recreation and other supportive services for rural Native Americans. Site managers will oversee the operation of the vans and senior aids and volunteers will be instrumental in the day-to-day operations. The project period for the demonstration program is three years beginning October 1, 1991 with support from the Administration on Aging. Funding for the volunteer van program is divided between FY 1991 and FY 1992.

The Administration on Aging worked with the General Accounting Office in their review of transportation services for the elderly. The GAO report was prepared and distributed in FY 1991.

AoA is a member of the joint DOT/DHHS Coordinating Council on Human Services Transportation. As a member, AoA works with the Council to address Federal barriers to coordination of transportation services, promote coordinated transportation planning and programming, coordinate technical assistance and program guidance and information dissemination.

Under the Coordinating Council Technical Assistance efforts, AoA Regions I and IX supported the efforts of Department of Health and Human Services and the Urban Mass Transportation Administration which co-sponsored a Western Regional Conference in Long Beach, CA on integrated client transportation and a similar conference in Hartford, CT. One of the most successful aspects of each conference was the opportunity for human service providers to hear coordination success stories from their peers.

As part of its Council activities, AoA prepared an information memorandum to the State and Area Agencies on Aging on a document prepared by the Department of Health and Human Services, Office of Inspector General Report on Cost-sharing.

AoA also distributed a report on the Field Forums conducted by the U.S. Commissioner on Aging which contained a discussion on cost sharing.

FIRE SAFETY

A fire in the home still remains one of the greatest fears of an older person. During FY 1991, AoA undertook two efforts in the area of fire safety. AoA discussed with the Consumer Product Safety Commission a fire safety issue related to elderly nightwear. As a result, an information memorandum was distributed to the State and Area Agencies on Aging addressing prevention tips for senior citizens. The State and Area Agencies on Aging made the suggestions from the U.S. Consumer Product Safety Commission available to senior centers and nutrition sites.

The second effort was the development of a resource booklet titled, "Elder Fire Safety for the '90s: Your Guide to National Resources". This booklet contains important information about programs and resources that can help protect older Americans against the tragedy of home fires. Many of these programs cited were developed with support from AoA and most were designed through the mobilization of local resources that reflect the mission of the National Eldercare Campaign. This booklet was produced by the University of Southern Maine under a grant from the Administration on Aging. The Southern Maine grant will be discussed under Title IV program section of the Annual Report.

NATIONAL SURVEY ON RECREATION AND THE ENVIRONMENT

AoA has been part of a Work Group with the U.S. Department of Commerce, National Oceanic and Atmospheric Administration and the U.S. Department of Agriculture, Forest Service. The goals of the Work Group are to establish benchmark data to help policymakers and decisionmakers understand recreational use of public attitudes toward our national natural resources. A portion of the survey will replicate previous National Recreation Surveys, enabling scientists to identify recreation trends over a 30-year period dating back to 1960. Currently, the National Survey on Recreation and the Environment (NSRE) is recruiting sponsors for this nationwide research effort, developing questionnaire modules and sampling plans. OMB clearance is scheduled for winter of 1991.

COLLABORATION WITH SOCIAL SECURITY AND HEALTH CARE FINANCING ADMINISTRATIONS

In Support of the AoA/SSA/HCFE Memorandum of Understanding which was signed in FY 1990 to promote and enhance collaboration of aging services. AoA, SSA, and HCFE worked together to develop initiatives to support the following objectives: (1) improve coordination of services funded under the program authorities of AoA, SSA, and HCFE which relate to older persons; (2) increase public awareness of SSA and HCFE entitlement, the nutrition and supportive services programs of AoA, and other programs which promote the well-being of older persons; (3) to increase participation in SSA and HCFE entitlement programs, nutrition and supporting services programs of AoA, and other programs which promote the well-being of older persons through special outreach efforts which focus on "hard to reach" individuals such as low-income minorities, non-English speaking and rural older persons; (4) reduce dependence on entitlement programs by improving personal financial security and increasing employment opportunities for older persons, particularly those with disabilities; (5) improve health care for vulnerable older people.

During FY 1991 the following activities were undertaken in support of this MOU:

SSI OUTREACH EFFORTS

AoA and SSA issued discretionary grant announcements which sought to demonstrate innovative and transferable approaches for increasing public awareness and participation in the SSI program and other public benefits. The work group facilitated this activity by ensuring appropriate SSA and AoA collaboration on the development of the announcement; the dissemination of the announcement to the aging agencies and organizations; and review of grant applications. AoA has encouraged the State and Area Agencies on Aging, and Tribal Organizations to submit applications for FY 1992 funds for a series of the Social Security Administration SSI Outreach Demonstrations.

OLDER AMERICANS SERVICE COORDINATION PILOT

AoA and SSA jointly conducted a pilot project to provide a single focal point for information and referral concerning the Department's programs as well as Department funded public and private agency programs and services. This pilot was incorporated into the Secretary's Integrated Services Delivery Initiative. As part of Phase II of the initiative, AoA and SSA will identify best practice models of successful collaborative activities between Area Agencies on Aging and SSA field offices. AoA will promote the replication of these successful models across the nation.

AOA/SSA/HCFE PUBLIC INFORMATION PAMPHLET

Through the efforts of the work group, AoA/SSA/HCFE published a joint public information pamphlet titled, "Services and Benefits for Older Persons, Are you Eligible?" The pamphlet provides basic information about each of the programs with special emphasis on eligibility requirements for older American Act nutrition and supportive services programs, Social Security benefit programs, and Medicare/Medicaid. The pamphlet has been printed in both english and spanish.

AOA/SSA/HCFE/INFORMATION DISSEMINATION

AoA and SSA assisted HCFE with the dissemination of a variety of materials on Medicare to their respective networks. This included information on the Qualified Medicare Beneficiary program, Medigap Insurance Counseling program, videotapes, and other requirements. AoA assisted SSA with distribution of SSI Outreach information and posters to the State and Area Agencies on Aging, Tribal Organizations and the Leadership Council on Aging Organizations.

SECTION II—TITLE III SUPPORTIVE AND NUTRITION SERVICES

INTRODUCTION

The Administration on Aging (AoA) is the lead component within the Department of Health and Human Services on all issues concerning Aging. It advocates for the needs of the elderly in program planning and policy development; provides technical assistance; issues best practices guidelines; and initiates policy relative to funding the States and Territories for the provision of services to older Americans under Title III (Grants for State and Community Programs on Aging).

Each State Agency is required to subdivide the State into Planning and Service Areas (PSAs) and to designate within each PSA an Area Agency on Aging (AAA) to be specifically responsible for carrying out the purposes of the Act within the PSA. While most States have a statewide network of Area Agencies on Aging, fourteen States/Territories have designated their entire geographic area as a single PSA with the State agency performing the Area Agency functions because of their small geographic areas or population size.

STATE AGENCIES ON AGING

The Older Americans Act intends that the State Agency on Aging shall be the leader relative to all aging issues on behalf of all older persons in the State. This means that the State Agency proactively carries out a wide range of functions related to advocacy, planning, coordination, interagency linkages, information sharing, brokering, monitoring and evaluation designed to develop or enhance services for older persons throughout the State. Fifty-seven States and other jurisdictions receive support under Title III of the Act. States may elect durations of 2, 3 or 4 years for State and Area Plans.

The State Agencies assure that the resources made available to Area Agencies on Aging under the Older Americans Act are used to carry out the Area Agency mission of assisting older persons in leading independent, meaningful and dignified lives in their own homes and communities as long as possible.

State and Area Agencies on Aging work to facilitate the most effective use of all community resources, both public and private, to provide for appropriate services to older persons within the many communities of the Planning and Service Area. To effectively accomplish this goal, there must be a community-wide effort with all appropriate resources, programs, and personnel carefully coordinated.

AREA AGENCIES ON AGING

In FY 1990, there were over 670 Area Agencies on Aging operating under Title III of the Act. As of the end of FY 1990, there were approximately 679 Planning and

Service Areas, including the 14 Single Planning and Service Areas, previously mentioned, covering whole States and Territories. An Area Agency on Aging may be a public or private organization, an Indian Tribe or a sub-State regional body. Area Agencies on Aging have the major responsibility for the administration, at the sub-State level, of Title III funds for supportive and nutrition services. Area Agencies receive their funds from the State Agency on Aging and then award grants and contracts to local supportive and nutrition service providers under an approved area plan.

Area Agencies on Aging are responsible for providing technical assistance to and monitoring the effectiveness and efficiency of, their respective service providers. Through their coordination and planning activities, Area Agencies also address the concerns of older persons at the community level. Area Agencies interact with other local public and private agencies and organizations in order to coordinate their respective activities and elicit or "leverage" additional resources to be used on behalf of older persons.

FUNDING STATE AND AREA AGENCIES ON AGING

State Agencies on Aging received a total of \$751.8 million of Title III funds during FY 1990. Funds under this Title of the Act are made available to the States on a formula basis upon approval of State Plans by AoA Regional Offices. States then allocate funds to Area Agencies based upon approval Area Plans to pay up to 85 percent of the costs of supportive services and senior centers, and nutrition services. In most cases, Area Agencies on Aging then arrange with both nonprofit and proprietary service providers to deliver nutrition and other services described in the Area Plan.

In general, funds provided to Area Agencies are used for the administration and provision of a wide range of supportive and nutrition services authorized under Parts B, C, D, Ombudsman Activities and G of Title III as described in the next paragraph.

TITLE III SERVICES

Title III activities conducted in the States during FY 1991 were based upon State plans ranging in duration from two to four years. In FY 1991 six separate allocations under Title III were made to States for: (a) supportive services and senior center operations; (b) congregate nutrition services; (c) home-delivered meals; (d) in-home services for the frail elderly; (e) programs to prevent abuse, neglect, and exploitation of older individuals; and (f) ombudsman activities. The 1987 Amendments to the Older Americans Act newly established Part D to Title III for in-home services for the frail elderly.

Title III-B supportive services are designed to provide assistance to all older persons, with particular attention to older persons in greatest economic or social need. Most supportive services fall under three broad categories: access services; in-home services; and other community and neighborhood services. Access services are transportation, outreach, and information and referral. Most in-home services are homemaker, personal care, chore, and/or visiting and telephone reassurance. Community and neighborhood services include legal services, residential repair, escort services, health services, physical fitness programs, pre-retirement and second career counseling, and other services.

Data on Title III services and program operations are reflected in State Program Reports which are sent to AoA Central Office each year by the State Agencies on Aging through AoA's ten Regional Offices. The Title III State Program Reports for FY 1990 were analyzed during FY 1991. These data provide a national summary of the Title III program including such information as participation levels, expenditures, and units of service by service category. This information is responsive to Sections 207 (a)(1), (a)(2), and (a)(4), as required by the 1987 Amendments to the Older Americans Act. Selected program data are presented in the following paragraphs.

The 1987 Amendments to the Older Americans Act require the Administration on Aging to report to Congress specific information regarding the programs and activities under the Act at the end of the fiscal year. The information collected by the States in FY 1991, to be reported as called for by Sections 207 (a)(1), (a)(2), and (a)(4) is currently being analyzed and will be included in the Annual Report for FY 1992.

TITLE III-B SUPPORTIVE SERVICES

In FY 1990, the Title III-B program reached an estimated 7.1 million older clients in need of access, in-home, and community-based services. In FY 1990, 18.5 percent

of all participants were racial and ethnic minorities and 37 percent were low income. In the area of access services, transportation was the most frequently provided service, followed by information and referral, then outreach. In the area of in-home services, housekeeping assistance was reported most frequently, followed by reassurance to elderly persons through telephone contacts, and then chore services. In the community-based services area, recreational services were most frequently provided, followed by education and training, escort, and legal services.

TITLE III-C, CONGREGATE AND HOME DELIVERED NUTRITION SERVICES

Congregate and Home-Delivered Nutrition Services, authorized by Title III-C, continue to be an integral part of the systems which communities are developing to assist their older citizens in maintaining independence and remaining in their own homes as long as possible.

CONGREGATE NUTRITION SERVICES

Over 142 million congregate meals were served to older people and their spouses during FY 1990. In addition to Title III-C funds, these meals are also supplemented and supported by United States Department of Agriculture funds; Social Services Block Grant program funds; other Federal, State, and local funds; and participant contributions. Nearly 2.7 million elderly received meals at congregate sites.

HOME-DELIVERED MEALS

Home-delivered meals are also critical to the maintenance of independence for older persons who are unable to participate in congregate meals programs. During FY 1990, 101.8 million meals were provided to the homebound elderly from Title III-C and other funding sources. This number represents an increase over the 99.6 million home-delivered meals served in FY 1989. A total of 792,452 older persons received home-delivered meals.

TITLE III-D, IN-HOME SERVICES FOR FRAIL ELDERLY

Title III-D, In-Home Services for Frail Older Persons, was established by the 1987 Amendments to the Older Americans Act. During FY1990, more than 88,000 frail older persons received in-home services under the Title III-D program.

TITLE III-G, PREVENTION OF ABUSE, NEGLECT, AND EXPLOITATION OF OLDER INDIVIDUALS

Established by the 1987 Amendments to the Older Americans Act, Title III-D was first funded in FY 1991. Program data will be analyzed for FY 1991 and reported in AoA's 1992 Annual Report to Congress.

OMBUDSMAN PROGRAMS

State agencies use part of their Title III-B (Supportive Services and Senior Centers) funds and funds from other sources to establish and maintain long-term care ombudsman programs at the State and sub-State levels. In addition, in FY 1991 Congress provided a separate allocation of funds for ombudsman activities. Program data related to this latter funding will be included in the 1992 Annual Report.

Through their ombudsman programs, States have addressed such issues as nursing home regulations, abuse of residents' personal funds, and restrictions on access to nursing homes. Complaint statistics and program data for the FY 1990 reporting period were analyzed during FY 1991. Some highlights of these data are as follows:

During FY 1990 there were 578 sub-state programs

Total funding for State and local ombudsman programs in FY 1990 increased from approximately \$25.2 million in FY 1989 to about \$27.9 million. In addition to Title III-B funds, State and local governments used funds from other sources, including State, county, and local revenues, grants under Titles IV and V of the Older Americans Act, and other funding sources.

WAIVERS AS RELATED TO PRIORITY SERVICES

The Older Americans Act, as amended, requires that the Administration on Aging collect and report special information about access, in-home, and legal assistance services. Section 307(a)(22) requires that each State Agency include in its State Plan a minimum percentage of Title III-B funds which each Area Agency must expend on these services. Otherwise, the State grants a waiver to the Area Agency. Section 306(a)(2) describes the requirements which must be met by an Area Agency when

requesting a waiver from providing the required minimum amount for one or more of these priority services (access, in-home, and legal assistance) and by the State Agency in granting any such waiver request.

Pursuant to Sections 207(a)(2) and 306(b)(2)(d) of the Act, the Administration on Aging compiles a report on waivers of priority services as required under the Act; however the data for this year's report are not available at the time of submission of this report.

The Act permits State Agencies to grant waivers to Area Agencies that have not expended the mandated minimums for priority services. The Act also requires the State Agency to follow rigorous procedures in their respective granting and review of waivers.

The data from the previous year suggest that there is a high level of compliance with the provisions of the Act. The States have set minimum expenditure levels for the priority services.

For most Area Agencies on Aging the States report that the actual expenditure levels have been met.

It is clear that the States have taken the Congressional mandate seriously as well as the freedom to define appropriate proportion.

ADVOCACY AND PARTNERSHIPS

In advocating for older persons, State and Area Agencies on Aging review and comment on State and community policies, programs and issues; provide testimony at public hearings; publish reports; coordinate and provide technical assistance to other public and private agencies and organizations; and leverage resources from other Federal, State and local programs, as well as private charitable and business resources.

NON-FEDERAL RESOURCES AND PROGRAM INCOME

The Title III program has evolved from a relatively simple program of community service projects for older persons into a complex and highly differentiated "national network on aging" currently consisting of 57 State Agencies and over 670 Area Agencies on Aging and more than 25,000 local nutrition and supportive service providers. These nutrition and supportive service providers are local public, private, or voluntary organizations. Not only do the State and Area Agencies on Aging use Title III moneys to provide for services, they also are instrumental in leveraging other public and private moneys in addressing the needs of older persons.

Title III regulations (45 C.F.R. Part 1321) require each service provider to "provide each older person [receiving services] with a full and free opportunity to contribute toward the cost of the service." Although AoA emphasizes through the aging network that this is not a fee and that contributions are entirely voluntary, these contributions have been steadily increasing, as follows:

Fiscal year:	<i>Million</i>
1981.....	\$ 79.0
1982.....	100.8
1983.....	116.7
1984.....	131.7
1985.....	140.1
1986.....	153.9
1987.....	163.6
1988.....	168.1
1989.....	179.0
1990 (approx.).....	185.3

SECTION III—SERVICES TO OLDER NATIVE AMERICANS

TITLE VI GRANTS FOR NATIVE AMERICANS

Under Title VI of the Older Americans Act, the Administration on Aging annually awards grants to provide supportive and nutritional services for older Native Americans. The Amendments to the Older Americans Act in 1978, added Title VI—"Grants to Indian Tribes." In the Older Americans Act Amendments of 1987 (P.L. 100-175) Title VI was renamed "Grants for Native Americans," and older Native Hawaiians were added to the American Indians and Alaskan Natives already being served by Title VI. Title VI was divided into two parts, Part A—Indian Program, and Part B—Native Hawaiian Program. The first grant under Part B was made in fiscal year 1989.

In fiscal year 1991, 18 additional tribal organizations received funding from Title IV Part A, for American Indians and Alaskan Natives. This increased the grantees from 193 to 211. The funding increased from \$11,107,961 for fiscal year 1990 to \$13,133,811 for fiscal year 1991.

Under Title VI Part B, for Native Hawaiians, the funds awarded, as specified by the 1987 Amendments, increased from \$1,433,000 for fiscal year 1990 to \$1,500,000 for fiscal year 1991.

ELDERS ELIGIBLE UNDER TITLE VI

Persons eligible for services under Title VI Part A are tribal members age 60 or over living in a Tribe's Title VI service area, and members under age 60 if the Tribe has selected a younger age for "older Indian." The Older Americans Act Amendments of 1981 allowed Tribes to set a younger age for "older Indian", if considered appropriate. The 211 grantees of Title VI Part A for fiscal year 1991 estimated that 76,828 older Indians were eligible for services, including 61,795 age 60 or over, and 15,033 under age 60.

For services under Title VI Part B, the Native Hawaiians must be age 60 or over. Alu Like, the statewide grantee, estimated that 1,300 older Native Hawaiians were in the proposed Title VI Part B service areas on the five major islands and thus were eligible for Title VI services. The grantee estimated that there were a total of 10,876 older Native Hawaiians in the entire State of Hawaii.

SERVICE UNDER TITLE VI

Congregate and home-delivered meals, and a variety of supportive services were provided by Indian Tribes under Title VI Part A. All grantees provided the required service of information and referral unless other arrangements existed. Other supportive services were provided, included transportation, counseling, home assistance services, etc.

Approximately 2,052,000 meals were provided under Title VI Part A in fiscal year 1991, including 1,058,000 congregate meals, and 994,000 home-delivered meals.

Approximately 32,000 meals were provided under Title VI Part B in fiscal year 1991.

CONTRIBUTIONS TO THE ELDERCARE CAMPAIGN

In 1991 the Office of American Indian, Alaskan Native, Native Hawaiian Program established an Eldercare Work Group with representatives from the Administration on Aging central office, three regional offices, and eight Tribal Organizations. The purpose of the workgroup is to provide a means of exchange between the participating members in order to develop and promote the implementation of an effective strategy for eldercare in diverse Indian communities. Each member will then develop a comparable gathering and get input from people in their communities.

Eldercare was further promoted through the Three Feathers Leadership Training (funded through Title IV) in the spring of 1991. Representatives from 34 Tribal Organizations attended this training where the Administration on Aging had an opportunity to discuss the Eldercare initiative. Participants shared how they are educating others on the needs of the "at-risk" elderly and how they had begun reaching out to nontraditional resources.

The National Title VI Directors Association was awarded a grant by the Administration on Aging to conduct a public awareness campaign on the needs of "at-risk" Native American, Native Alaskan and Native Hawaiian elders. The purpose of the campaign is to educate individuals, agencies, organizations, and businesses on the needs of "at-risk" Native American, Native Alaskan and Native Hawaiian elders and to secure resources to improve the quality and increase services to this population.

ADMINISTRATIVE PROCEDURES

On April 1, 1990, in an effort to reduce the paperwork burden, a change was made in the administration of grants under Title VI. Previously AoA grants had been processed by the Grants and Contracts Management Division of the Office of Human Development Services, using an annual application on Standard Form 424.

Beginning April 1, 1990, Tribes now provide a narrative plan and send their application to the AoA Regional Offices. The award period is from 2 to 3 years without additional application. The Regional Offices review and recommend approval of

each plan to the Commissioner on Aging, who gives final approval for the entire period.

TECHNICAL ASSISTANCE

AoA awards an open and competitive technical assistance contract to aid Title VI grantees in matters of program planning and administration. The contract provides group meetings and individual on-site technical assistance. Reports from the contractor show that the grantees request technical assistance primarily on the following subjects: Title VI and Title III coordination; budget and program management; nutrition; and service development.

OFFICE FOR AMERICAN INDIAN, ALASKAN NATIVE, AND NATIVE HAWAIIAN PROGRAMS

In March 1991 the Commissioner on Aging appointed the Associate Commissioner for Office for American Indian, Alaskan Native, and Native Hawaiian Programs. This new office was charged with the responsibility to serve as the focal point within AoA for the operation and assessment of programs authorized under Title VI of the Older American Act (OAA) and to provide program and policy direction to the ten Regional Offices of AoA in the execution of their Title VI responsibilities. Additional functions of the Office are to serve as the effective and visible advocate on behalf of older Native Americans, to coordinate activities with other Federal departments and agencies, to administer and evaluate grants provided under the OAA to Indian Tribes and public and nonprofit private organizations serving Native Hawaiians, and to collect and disseminate information related to the problems of older Native Americans.

INTERAGENCY TASK FORCE ON OLDER INDIANS

The 1987 amendments in Section 134(d) directed the Commissioner on Aging to establish a permanent Interagency Task Force on Older Indians, with representatives of departments and agencies of the Federal Government with an interest in older Indians. This Task Force was established in fiscal year 1990 and became fully functioning in fiscal year 1991.

During the first year of its existence, the Task Force cooperated in a number of activities in three different areas:

(a) *Collaboration of Specific Activities.* These included activities supported through either discretionary funds, special priority program funds or dissemination of information. For example, the Administration on Native Americans (ANA) is supporting two projects for which the Health Care Financing Administration (HCFA), the Veterans Administration (VA), the Administration on Aging (AoA) and the National Institute on Mental Health (NIMH) have committed support of ANA's projects either through collaborative funding, shared program resources and linkages, or dissemination of information. Another example involves the Health Resources and Services Administration (HRSA) working with the AoA to link the Geriatric Education Centers (GEC's) with colleges, AoA and HRSA are exploring ways in which the GEC's can be used as technical assistance and resource centers to further the goals of Eldercare, with a special emphasis on Indian Elders. HRSA has also agreed to include information on Eldercare, in its Geriatric Education Center Newsletter. In return, AoA will provide programmatic information about reauthorization of the Older American's Act to HRSA for publication in its newsletter.

(b) *Influencing Agency Priorities.* The second type of collaboration involves influencing an agency's policies so that each agency's national program priorities and functions are designed to respond to the needs and conditions reflected in the lives of Indian Elders and, at the same time, are coordinated with other agencies to maximize collaboration and effective program operations toward the goal of enhancing services to Indian Elders.

Since the Task Force has no authority to require interagency collaboration, each participating agency needs to recognize the advantages of collaboration and incorporate the concept throughout its planning and operations. This has become the basis for the Task Force's current endeavors and future plans and recommendations.

(c) *Enhancing Task Force Goals or Program Service Delivery.* Finally, there are those types of support or actions by Task Force members which benefit either the Task Force generically or enhance the service delivery of one or more programs. For example, the Department of Commerce is pursuing the development and release of data which could be used as a foundation for a common data base accessible by all participating Task Force agencies.

A second example involves the Social Security Administration (SSA) and its Supplemental Security Income (SSI) program. SSI has launched a comprehensive out-

reach campaign to increase participation, especially by those individuals who are traditionally hard to reach. As part of its strategy, SSA is reviewing the application forms and the process by which eligibility is established to determine if applying for benefits can be easier. This would improve access to SSI program benefits in some Indian communities and increase participation not only in SSI but potentially in Medicaid.

Another example of this type of collaboration involves AoA's support of the Inter-agency Task Force through funding a contract to provide logistical support to conduct Task Force meetings, enabling expert witnesses to attend, providing the means for ongoing advice from different Indian constituencies, providing technical training as the Task Force determines the need for it, conducting analyses and preparing reports. A number of member agencies have also provided staff support for different activities, as the need arose.

Experts from different Indian tribal communities shared their perspectives on how these programs operate at the community level.

OLDER INDIAN TASK FORCE RECOMMENDATIONS AND FUTURE PLANS

The agency's overall goal as a Task Force has been statutorily established, that is, to improve collaboration among Federal agencies in order to enhance services and programs to Indian Elders. Doing this will promote long range, integrated types of collaboration. Within this context, the Task Force recommends that it continue its work in the following areas:

a. *Development of a common data base of vital information.* This would permit each agency to utilize common data in developing their plans and initiatives, individually and collaboratively, thereby supporting effective intra- and interagency program planning, implementation and assessment for both short-term projects and long-range collaboration.

b. *Promotion of needs and interests of Indian Elders within each participating agency is one of the long range goals of the Task Force.* Members of the Task Force will work within their agency to support the needs and interests of Indian Elders to assure the agency mandates, operative procedures and practices become more focused in order to enhance programs and services to Indian Elders, and to increase their access to these services. To achieve this will require the following:

1. The development of education/information materials, including videos through the AoA Task Force support contract that are usable both to educate agency staff about Indian culture and the historical special relationship between the Federal government and Indian tribes and peoples, and by Indian Elders to learn about Federal programs and resources and their rights to participate.

2. The initiation of workgroups within each agency comprised of representatives of key program components who would function as educators, advocates and agents of change in promoting Indian interest within the agency. Intra-and-interagency collaboration in focusing program resources and policies on Indian Elders would be promoted through these in-house work groups. They would also serve as the means to educate program staff about Indian cultures, living conditions and their traditional, historical status.

3. Launching a major interagency effort nationwide to educate relevant staff, including program, policy, and field staff, as well as program beneficiaries using the different sets of educational materials described under (1a) above.

4. Expand the function and scope of the support contract which has made a significant contribution enabling the Task Force to carry out its work.

SECTION IV—TRAINING, RESEARCH, AND DISCRETIONARY PROJECTS AND PROGRAMS

PURPOSE OF TITLE IV

Title IV—Training, Research, and Discretionary Projects and Programs—supports the goals of the Older Americans Act by funding model projects and research and by educating and training professionals in fields which have an impact on the aging. Through these projects, the Administration on Aging (AoA), provides valuable support to the National Eldercare Campaign, helps to build the capacity of State and Area Agencies on Aging and other organizations to provide services to the aging, to

promote linkages among organizations which serve older persons, and takes a leadership role in better preparing the country for an aging society.

Projects funded under Title IV complement and support the services provided through other sections of the Older Americans Act. Training and technical assistance to State and Area Agencies on Aging is provided through National Eldercare Institutes with expertise in such areas as community based long-term care, elder abuse and ombudsman programs, transportation, and health promotion. Through Title IV, AoA promotes minority management and leadership of aging programs and agencies, development of university faculty who are more informed about aging, and career preparation of students in disciplines relating to aging. Health promotion activities for older Americans are supported through Title IV by a number of projects as are model projects for serving the vulnerable elderly. Strategies for cultivating public/private partnerships and strengthening the family are developed through Title IV as well as models for using older persons as resources. As part of the Small Business Innovation Research Program, AoA also awards contracts to small businesses to develop innovative technology which will benefit the elderly.

1. NATIONAL ELDERCARE CAMPAIGN

Early in 1991 the Administration on Aging (AoA) launched the National Eldercare Campaign, a call for individual and collective action to mobilize additional resources for home and community-based care for older persons at risk of losing their self-sufficiency. The Campaign is a response to the challenges of an aging society confronting increasing vulnerability and the multiple demands upon limited resources. Through public awareness, organizational outreach and community action the Campaign seeks to broaden the base of involvement and commitment to the Nation's vulnerable elderly.

In order to achieve this goal AoA and the aging network are promoting advances on a broad front, including encouragement of public/private sector partnerships, unleashing the untapped potential of older volunteers and others willing to assist those less fortunate elderly, and promoting visionary thinking and action concerning the impact of an increasingly aging society.

A. NATIONAL ORGANIZATIONS

Earlier this year, AoA Central and Regional Office staff began a series of contracts with selected associations and organizations outside the traditional aging network, to gain their commitment and participation in aging issues and the Eldercare Campaign. These outreach efforts are resulting in a number of agencies and organizations that want to be more involved in a substantial and significant way in the Eldercare effort and a number of referrals to additional sources. AoA staff are engaged in developing substantive program initiatives with organizations which have shown interest in the Campaign and are working with them in designing strategies for incorporating these initiatives as an integral part of community based services and opportunities.

To encourage national organizations and associations to develop Eldercare agendas within their own memberships and affiliations, AoA included two priority areas for support of this activity in its FY 1991 Discretionary Funds Program Announcement.

1. NATIONAL AGING ORGANIZATIONS

FY 1991 project awards were made to seven national aging organizations to stimulate new initiatives for addressing home and community based care needs of older persons at risk and to expand public awareness relating to the problems and issues of eldercare. Organizations receiving awards were:

- National Society on Aging (San Francisco, CA)
- National Title VI Directors Association (Tahlequah, OK)
- American Bar Association (Chicago, IL)
- National Caucus and Center on Black Aged, Inc. (Washington, DC)
- National Hispanic Council on Aging (Washington, DC)
- Save Our Security Education Fund (Washington, DC)
- Asociacion Nacional Pro Personas Mayores (Los Angeles, CA)

2. NON-AGING NATIONAL ORGANIZATIONS

Fiscal year 1991 project grant awards were made to 11 national (non-aging) organizations for promoting awareness among their affiliates and members of the necessity for immediate and substantive action in preparing for an aging society and inte-

gration of eldercare into their ongoing society agendas. Organizations receiving awards were:

- Catholic Charities, USA (Arlington, VA)
- National Council of Negro Women (Washington, D.C.)
- American Medical Association (Chicago, IL)
- National Association of Counties (Washington, D.C.)
- National Easter Seal Society (Chicago, IL)
- Public Health Association (Washington, D.C.)
- Health Insurance Association of America (Washington, D.C.)
- National Black Caucus of State Legislators (Washington, D.C.)
- American Institute of Architects/American Council of Schools of Architecture Research Council (Washington, D.C.)
- National Association of Social Workers (Silver Spring, MD)
- American National Red Cross (Washington, D.C.)

B. OLDER AMERICANS ACT ELDERCARE VOLUNTEER CORPS

Volunteers have long been the backbone of Older Americans Act service systems since 1965. The U.S. Commissioner on Aging announced in April the establishment of the Eldercare Volunteer Corps to recognize the nearly half million persons who have devoted their time as volunteers in Older American Act programs and to encourage the expansion of volunteer efforts by heightening public awareness of the volunteer opportunities available.

In June, AoA issued guidelines to State Agencies on Aging for application of funds to support the Eldercare Volunteer Corps and serve as an incentive to States to bring together key actors to examine current volunteer activities, plan the shape of future volunteer efforts, and to begin to implement such a plan. Twenty-eight 1-year project awards were made in August to the following State Agencies on Aging; Alaska, Arizona, Arkansas, Connecticut, Colorado, Delaware, Idaho, Illinois, Iowa, Kansas, Louisiana, Massachusetts, Mississippi, Montana, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, and Wisconsin.

C. PROJECT CARE

Project CARE was launched in May 1991 for the development of a multiyear program to promote community action on behalf of the at risk elderly in danger of losing their independence. Project CARE Coalitions are being established in nearly 300 communities nationwide to identify a problem of primary importance to the vulnerable elderly, develop a community coalition of partners to advocate and develop new and innovative approaches in mobilizing resources to respond to the need.

Each State Agency on Aging, through its Area Agencies, is establishing at least three Project CARE communities to expand home and community based services.

Under the 1991 Discretionary Grant Announcement, AoA has funded 16 Area Agencies to develop three Project CARE Coalitions in three different communities within the Planning and Service Area covered by the Area Agency. Phase II of these latter projects calls for replication of the coalition building in three more communities within the planning and service area. Awards were made to the following agencies:

- Western Connecticut Area Agency on Aging with Sullivan Senior Center (Torrington, CT)
- Eastern Connecticut Area Agency on Aging with the Day Kimball Hospital (Putnam, CT)
- West Central Florida Area Agency on Aging, Inc. with Suncoast Gerontology Center, University of South Florida (Tampa, FL)
- Hawaii County Office of Aging with Vocational Rehabilitation Associates, Inc. (Hilo, HA)
- Kentuckiana Area Agency on Aging with Family and Children's Agency (Louisville, KY)
- Commission on Affairs of the Elderly with Family Services of Greater Boston (Boston, MA)
- Western Michigan Area Agency on Aging with Alliance for Health (Grand Rapids, MI)
- Detroit Area Agency on Aging with Ecumenical Project S.A.V.E. (Detroit, MI)
- Area Agency on Aging 1-B with (Turner Geriatric Clinic)
- Central Ohio Area Agency on Aging with Coalition for Elder Care (Columbus, OH)
- Tri-County Office on Aging with Lansing General Hospital (Lansing, MI)

Missoula Aging Services with new (unnamed) coalition President of Coalition (Missoula, MT)

Mid-East Commission Area Agency on Aging with Pitt Interfaith Caregivers (Greenville, NC)

Council on Aging with South West Ohio Seniors' Services, Inc. (Cincinnati, OH)

Upper Cumberland Development District Area Agency on Aging with Cumberland County (Crossville, TN)

Central Texas Area Agency on Aging with the Ministerial Alliance of Hamilton County (Dallas, TX)

D. MEDIA CONTRACT

To assist in gaining greater public awareness and alert the public to the need for collective action in meeting the challenges of an aging population, AoA awarded a media contract to Global Exchange, Inc., of Chevy Chase, MD. This contractor is in the process of developing a work plan which will address a communication strategy for conveying goals and objectives, ways of conveying information to target audiences, development of themes and messages, and helping AoA with the public awareness aspects of the Campaign. Global Exchange, an organization with extensive experience in social issue public awareness, will assist AoA in publishing a newsletter, development of public information packages, and other materials.

E. SUPPORT CONTRACT

Emprise Designs, Inc., of St. Louis, MI will support AoA's management and coordination of the National Eldercare Campaign through (1) training and technical assistance to Project Care communities in coalition building; (2) conference and symposia logistics on various subject matter areas impacting on the at-risk elderly; and (3) collection and analysis and dissemination of various types of information and data prepared Campaign components. This contract will assist AoA with the coordination of the activities and components of the National Eldercare Campaign, including the Institutes. Among other tasks, the contractor is expected to:

Develop and administer a needs assessment survey instrument responsive, across the board, to the eldercare coalitions. The data and results generated by the needs assessment will be shared with each National Eldercare Institute;

Perform a clearinghouse function, including the development of a National Eldercare Calendar of all planned Eldercare events, use of an 1-800 number for access to technical assistance about coalition building, and management of a computerized bulletin board;

Prepare and publish a National Eldercare Campaign newsletter;

Provide assistance to Eldercare Coalitions in identifying and responding to the needs of at-risk elderly in their communities; and

Develop informational and other resource materials in support of the National Eldercare Campaign and coordinate their activities with other Eldercare Institutes.

In support of the National Eldercare Campaign, the Commissioner on Aging has funded the establishment of 12 National Eldercare Institutes. Each new Institute will focus on a critical substantive area relevant to improving eldercare services, both in the home and in the community. Each will address issues vitally important to those older persons struggling to maintain their self-sufficiency. Working in close collaboration with eldercare coalitions across the Nation, the Institutes will undertake a variety of activities designed to support and assist these coalitions to accomplish their mission.

1. LONG-TERM CARE

The National Eldercare Institute on Long-Term Care will be conducted by the National Association of State Units on Aging (Washington, D.C.) in collaboration with Brandeis University (Waltham, MA). The Institute will support the National Eldercare Campaign by being a resource on home and community-based care for the at-risk elderly population. Through consultation, training, and technical assistance, the Institute will enhance the capabilities of Eldercare coalitions to identify issues relevant to long-term care that need to be addressed in their communities. Such activities will also assist community and State coalitions to implement community care agendas and promote adoption of these agendas by segments of society that can build a broad base of support for Eldercare programs and services. In addition, the Institute will support the community long-term care agenda of the Eldercare Cam-

paign by developing resource materials and coordinating certain activities with other Eldercare Institutes.

2. ELDER ABUSE AND STATE OMBUDSMAN SERVICES

The National Eldercare Institute on Elder Abuse and State Ombudsman Services will be conducted by the National Association of State Units on Aging (Washington, D.C.) in collaboration with the American Public Welfare Association (Washington, D.C.) and the National Citizens Coalition for Nursing Home Reform (Washington, D.C.). The purpose of the Institute is to strengthen community, State and national efforts to combat elder abuse in domestic and institutional settings and to support the development and effective operation of Long Term Care Ombudsman Programs supported under Title III of the Older Americans Act.

The Institute will promote professional and public awareness of elder abuse through development and dissemination of educational materials and participation in meetings, conferences and workshops. It will provide training and technical assistance, develop practical guides, and disseminate information on exemplary programs, best practice models, and changes in State and Federal legislation to improve elder abuse and ombudsman services.

3. OLDER WOMEN

The National Eldercare Institute on Older Women will be directed by the National Council of Negro Women's (Washington, D.C.) in collaboration with the Older Women League (Washington, D.C.) and Brandeis University (Waltham, MA). The Institute is designed, over a three-year time span, to address issues affecting diverse populations of older women with special attention to those most at-risk.

In addition to giving assistance to coalitions of the National Eldercare Campaign, the Institute will have a major focus on encouraging national women's organizations to adopt an older women's issues agenda in their national and local program activities. The approaches to be taken in developing briefing papers and meeting agenda will include involvement of older women at all levels, but especially the frail vulnerable poor, rural and women of color. Among priority issues of older women at-risk of loss of independence to be addressed are those of income security, health, and family caregiving.

4. MULTIPURPOSE SENIOR CENTERS AND COMMUNITY FOCAL POINTS

The National Eldercare Institute on Multipurpose Centers and Community Focal Points will be conducted by the National Council on Aging (Washington, D.C.). The Institute's mission is to encourage communities to develop senior centers to serve at-risk older people in their home as well as in congregate facilities, and conversely, to encourage existing senior centers to expand their services for at-risk elderly and increase their linkages to nontraditional community groups.

In serving as a resource to the Eldercare Campaign and the Eldercare Coalitions, the Institute will develop a videotape on senior centers, establish a speaker's bureau for community presentations, and disseminate information briefs and newsletters to senior centers containing best practices for reaching at-risk elderly. To improve senior center management and attention to serving at-risk elderly, the Institute will increase training and technical assistance on the use of Senior Center Standards and on the development of senior centers as focal points for information and services. The Institute will publish and disseminate a senior advocacy guide which assists senior centers in giving encouragement to older persons to become their own advocates in their community.

5. TRANSPORTATION

The Eldercare Institute on Transportation will be conducted by the Community Transportation Association of America, (CTAA, Washington, D.C.) in collaboration with the National Association of Area Agencies on Aging (Washington, D.C.), the National Center and Caucus on Black Aged (Washington, D.C.) and the National Council on the Aging (Washington, D.C.). The focus of the Institute is to help aging and non-aging networks and coalitions develop, expand and improve transportation services for older persons at-risk.

The Institute will develop educational materials for improving transportation and increasing public awareness of its role in enhancing and maintaining the quality of life and maintaining the dignity and independence of the elderly. Existing data bases, including the National Transportation Resource Center operated by CTAA, will be used to synthesize practical information on the transportation and mobility needs of the at-risk elderly.

In addition to providing information, technical assistance, and a toll-free assistance hotline to Eldercare coalitions, the Institute will develop and disseminate training module and resource booklet which local planners can use to establish or enhance transportation services of elders in their communities.

6. HOUSING AND SUPPORTIVE SERVICES

The National Eldercare Institute on Housing and Supportive Services will be operated by the University of Southern California (Los Angeles, CA) in collaboration with the National Association of Area Agencies on Aging (Washington, D.C.) and the Federal National Mortgage Association (Washington, D.C.). The Institute will seek to mobilize public, private and voluntary sector resources to better link elderly housing with supportive services and increase supportive housing options for the at-risk elderly population.

The Institute will develop a variety of resource guides, fact sheets, briefing papers and reports on strategies to create housing coalitions and successful housing programs for the at-risk elderly. In addition to giving technical assistance to Eldercare coalitions, the Institute will involve traditional aging and housing organizations and new groups in public/private partnerships as one approach to raising public awareness of the need and ways to expand housing and support service options. Information will be synthesized on recent developments in housing programs that best serve at-risk elderly, including homesharing, accessory units, reverse mortgages, home modification and repair, and assisted housing.

7. NUTRITION SERVICES

The National Eldercare Institute on Nutrition will be conducted by the National Association of Nutrition and Aging Services Programs (Grand Rapids, MI) in collaboration with the National Association of Meals Programs (Washington, D.C.), the National Association of State Units on Aging (Washington, D.C.), the DuPont Corporation (Wilmington, DE), Ross Laboratories (Columbus, OH) and the Nestle Corporation (Washington, D.C.). The Institute will focus on nutritional issues of the at-risk elderly and their impact on improving nutritional services and product development in community settings.

The Institute will develop and disseminate educational and public information materials giving a basic understanding of the nutrition needs of at-risk older persons, the relationships between nutrition and health, the types of nutrition services that are effective and efficient, and strategies to develop new services or enhance existing ones. Through its private sector collaborators, the Institute will provide a link between community nutrition services and the food and packaging industry which will enable both to better serve the needs and preferences of the at-risk population.

8. HUMAN RESOURCES DEVELOPMENT

The National Eldercare Institute for Human Resource Development will be directed by the Brookdale Center on Aging, Hunter College of the City of New York (New York, NY) in collaboration with the American Society on Aging (San Francisco, CA). The Institute will promote the most effective use of human resources in programs serving the elderly, especially older persons at-risk.

The Institute will identify best practice approaches for recruiting, training, and retaining qualified eldercare personnel and disseminate this information to Eldercare Coalitions. It will prepare analyses of public policies affecting employment and training of personnel serving the at-risk elderly. It also will serve as a national clearinghouse and dissemination center on human resource development information and will disseminate a calendar of appropriate regional and national meetings and training events to organizations involved in the National Eldercare Campaign.

9. HEALTH PROMOTION

The National Eldercare Institute on Health Promotion is located at the American Association of Retired Persons (Washington, D.C.) in collaboration with Meharry Medical College (Atlanta, GA). The purpose of the Institute is to encourage healthy behaviors among older persons and their caregivers and serve as a knowledge base and program resource on health promotion, disease prevention, and disability prevention for vulnerable older persons.

The Institute will collect and disseminate information about successful health promotion program models which assist older persons in maintaining their well-being and independence and overcome barriers to reaching low income minority populations. Research findings and best practice information on health promotion will be

incorporated into technical assistance guides and training materials for use in conjunction with the work of national, State, and community Eldercare Coalitions and disseminated to health care networks.

10. INCOME SECURITY

The National Eldercare Institute on Income Security will be conducted by Families USA, Foundation, Inc. (Washington, D.C.). This Institute will focus on the living standards of the low-income elderly and their access to benefits and entitlement programs that meet their needs.

The Institute will conduct analyses on selected topics related to income security to identify key factors that can serve as the basis for a public awareness campaign and stimulate interest among Eldercare Coalitions, such as examination of the elderly poverty rate, a study of the "Medicaid Gap" as it relates to coverage of health services and nursing home care, the affordability of long term care insurance, and the proportion of out-of-pocket health costs not being paid by Medicare and Medicaid. The Institute will work with other interested organizations to promote outreach activities to bring attention low income elderly their possible eligibility as "Qualified Medicare Beneficiaries" to have Medicaid pay their Medicare premiums and deductibles. The Institute will also promote public education to increase participation of low-income elderly in the Supplementary Security Income (SSI) program.

11. EMPLOYMENT AND VOLUNTEERISM

The National Eldercare Institute on Employment and Volunteerism will be conducted by the Center on Aging, University of Maryland (College Park, MD) in collaboration with the National Council on the Aging (Washington, D.C.), the National Retiree Volunteer Center (Minneapolis, MN), and the American Association of Retired Persons (Washington, D.C.). The overall mission of the Institute is to improve the quality of life for older persons through enhancement of volunteerism and increase in employment opportunities.

The Institute will operate a clearinghouse for synthesis of knowledge and information reflecting curriculum and training models, effective programming, and policy analysis on volunteerism which can enhance effective use of volunteers in eldercare service organizations. A variety of media will be used to promote public awareness of eldercare service opportunities, including development of technical assistance materials and training modules which can be used by Eldercare Coalitions and other local organizations.

12. BUSINESS AND AGING

The National Eldercare Institute on Business and Aging will be conducted by the Washington Business Group on Health (Washington, D.C.) in collaboration with the American Society on Aging (San Francisco, CA). The Institute will focus on the development of linkages and partnerships between the business community and aging planning and service organizations and coalitions.

The institute will enlist the assistance of business organizations which have demonstrated a commitment to aging issues and aging organizations with expertise in the development of partnerships with business, as primary resources for expanding the number of partnerships between the business and corporate sectors. These experiences will be synthesized in resource materials and a newsletter, and used as case studies in seminars and presentations to business organizations. Special emphasis will be given to developing materials and approaches which encourage small and medium size and rural business to address aging concerns. The institute will also give special attention to assisting Eldercare Coalitions and aging agencies which have an interest in developing relationships with business.

II. RELATED TITLE IV NEW PROGRAM INITIATIVES

In addition to issuing a number of special grant and contract solicitation announcements for Title IV funding of the National Eldercare Campaign, AoA issued its regular annual Discretionary Funds Program Announcement during FY 1991. Three priority areas in this announcement called for grant proposals supporting the National Eldercare Campaign on topics described in the previous section. Other priority areas called for proposals on topics which complement and support the Eldercare Coalition. The following such activities were supported in FY 1991.

A. NATIONAL ACADEMY ON AGING

In 1991, the Administration on Aging entered into a three year cooperative agreement with Syracuse University to establish The National Academy on Aging at the All-University Gerontology Center in the Maxwell School of Citizenship and Public Affairs (Syracuse, NY).

The goals of the Academy are to encourage greater national leadership in aging issues. The Academy will bring together aging and non-aging leaders in American society to discuss the debate emerging trends and issues, as well as strategies regarding how they and their organizations can better address the challenges of an aging society. The Academy's faculty will develop curricula and present a number of symposia, seminars and conferences for national leaders. It will also conduct a variety of research activities in support of the National Eldercare Campaign. A comprehensive report on the theme "Aging in America 2000" will be produced by the end of the third year.

B. ENHANCEMENT OF DISSEMINATION AND UTILIZATION

The Title IV program has developed a wide range of usable findings and products. In some cases information about these findings and products has not been effectively disseminated to potential users such as Eldercare Coalitions. In FY 1991, AoA funded a cooperative agreement with the National Association of State Units on Aging to establish and jointly operate the National Eldercare Dissemination and Utilization Center. This Center will assist Title IV grantees to disseminate their findings and products through provision of technical assistance and training to current and former grantees. The Center will select some of the most promising projects and provide direct assistance in their dissemination to Eldercare Coalitions and aging planning and service organizations. It will also develop a range of general dissemination channels which can be used by Title IV grantees.

C. PROMOTING ACADEMIC INVOLVEMENT IN ELDERCARE

AoA has encouraged institutions of higher education to incorporate the concepts of the National Eldercare Campaign into the curricula of appropriate disciplines and professions to address the critical need for faculty and program development in the field of aging. These institutions of higher learning are in a position to greatly benefit the elderly now and in the future. They have at their disposal information, know-how, manpower and other resources, that, when applied to the problems facing the elderly could greatly retard the loss of independence in the at-risk older population.

Eight projects were funded in FY 1991 that reflect a variety of creative approaches to faculty and curriculum development and the incorporation eldercare initiatives into the academic environment. They include:

The University of North Texas (Denton, TX) to create linkages between faculty/student teams in colleges and universities, Area Agencies on Aging, and service provider contract agencies to build a cadre of academic faculty involved in eldercare coalitions.

Shaw Divinity School (Raleigh, NC) to build a continuing certificate program in eldercare ministries which will require students to participate in off-campus assessment on needs of 65+ Black elders in a two rural county area.

Portland State University (Portland, OR) to train faculty in coalition building, then involve them in development of eldercare coalitions.

Hunter College of the City University of New York (New York, NY) to link the community college system with service agencies on behalf of the Eldercare Campaign.

Tougaloo College (Tougaloo, MI) to combine research, training and information dissemination to improve the full spectrum of eldercare training and services in the State.

Baylor College of Medicine (Houston, TX) to conduct inservice faculty development in eldercare for key field placement site coordinators and add aging content to courses taken by 1,000 students.

Marygrove College (Detroit, MI) to expand its gerontology curriculum by involving students and faculty in the operations of its on-campus senior housing complex.

The State University of New York Health Sciences Center (Syracuse, NY) to train faculty from institutions throughout up-state New York in at-risk elderly topics and methods for coalition building, then pair them with local aging service planners and providers to involve campus resources in eldercare coalitions.

D. DISSERTATIONS

The Administration on Aging made 4 grant awards to support doctoral dissertations that focus on the eldercare needs of older persons at risk and the care provided such persons through home and community-based services. Awards were made to specific doctoral candidates at the following institutions:

The University of Minnesota (Minneapolis, MI) for a study of "Innovative Long-Term Care Programs For The Elderly;"

The University of California, San Francisco (San Francisco, CA) for a survey and review of "Adult Day Care Funding Strategies;"

Brandeis University (Waltham, MA) for a study of the "Massachusetts Adult Foster Care Program;" and

The University of Denver (Colorado Seminary) for an exploration of "Self-Neglect Among Elders In The Community."

E. MINORITY MANAGEMENT TRAINING PROGRAM

In FY 1991 AoA funded 5 special training projects under its continuing Minority Management Training Program to increase the number of qualified minorities in key management/administrative positions in State and Area Agencies and other agencies. The goal is to increase the professional credentials of minority trainees to help those individuals make the transition from a staff level to a managerial and administrative position. Projects awarded were:

Florida Agricultural and Mechanical University (Tallahassee, FL) to recruit, train and place within the State of Florida, minority interns in aging network agencies.

The Association Nacional Pro Personas Mayores (Los Angeles, CA) to recruit, train and place nationwide, Hispanic graduates in public and private aging-related agencies.

National Caucus and Center on Black Aged, Inc. to recruit and place nationwide, Black health care management graduates in long term care facilities to complete State required management training program and pass State licensure examinations.

Boston College (Boston, MA) to recruit minority persons for graduate training in social work and the management planning of elder services with field placement in eldercare agencies for placement in management positions in the aging network.

Association for Gerontology and Human Development in Historically Black Colleges and Universities (Washington, D.C.) to develop a model Minority Management Training Program in rural Eldercare service delivery.

F. HOME CARE WORKERS

To help meet the need to increase and improve the supply of paraprofessional home care workers, the Administration on Aging in FY 1991 funded four projects to test new, collaborative approaches for recruiting, training, and retaining in-home workers. The organizations approved for funding are:

The University of Kansas (Lawrence, KS), working in collaboration with Salish Kootenai College in Montana, to design and implement a model home care worker training program appropriate for American Indian settings;

The Denver Department of Social Services (Denver, CO), working in cooperation with the Department of Labor, Denver Area Agency on Aging, and the city school system, to demonstrate a program to provide job training skills and cash and supportive service incentives to prepare and hire Aid to Families with Dependent Care clients as home care workers;

The Marin County Area Agency on Aging (San Rafael CA), in collaboration with aging network agencies, county employment and training programs, and a county home care council, to develop a home care placement demonstration; and

The Council for Jewish Elderly (Chicago, IL) will develop training programs for three different audiences concerned with home care delivery: (1) independent home care workers; (2) family caregivers; and (3) home care providers.

G. ELDER ABUSE INITIATIVE AND ACTIVITIES

Secretary Louis Sullivan has assigned to the U.S. Commissioner on Aging and the Assistant Secretary for Planning and Evaluation joint responsibility for developing a U.S. Department of Health and Human Services Elder Abuse Strategy, with the cooperation and assistance of other appropriate units in the Department. An Elder

Abuse Task Force (consisting of the top leadership of AoA, the Office of the Assistant Secretary for Planning and Evaluation, the Health Care Financing Administration, the Public Health Service, and the Social Security Administration) will develop a detailed plan that recommends for the Secretary's consideration and decision: (1) short-term activity that would be carried out within current budget constraints and program authority and; (2) longer term policy, programmatic, and research issues.

Secretary Sullivan has made clear the commitment of the Department to take concerted action against elder abuse in *both* institutional and residential (home) settings. AoA's role in the implementation of the strategy will encompass efforts to: (a) promote the prevention of elder abuse whenever and wherever possible; (b) improve the reporting, investigation, and resolution of elder abuse cases through appropriate intervention services, and; (c) point toward better monitoring and follow-up of those cases to guard against reoccurrences of elder maltreatment.

III. VOLUNTEER SENIOR AIDES

In FY 1991, AoA implemented Section 10404 of the 1989 Omnibus Budget Reconciliation Act which authorizes a demonstration program for community-based projects to determine the extent to which provision of basic medical assistance and support by volunteer senior aides can reduce the costs of care for disabled or chronically ill children. The prototype program upon which the authorizing provisions were based is "Family Friends," an intergenerational program established in 1986 by the National Council on the Aging (NCOA), with funding support provided by the Robert Wood Johnson Foundation.

The Volunteer Service Aides Program announcement issued in June sought applications from Area Agencies on Aging working with community volunteer organizations for 3 year demonstrations which would:

- determine the extent to which the services of the volunteer aides contribute to:
- lower the costs of care for disabled and chronically ill children;
- promote the self-sufficiency of individuals and families vulnerable to a loss of independence;
- increase feelings of self-worth of the volunteer family aides; and
- increase collaboration among private, voluntary, and public sector organizations in establishing and operating community-based programs from which children, families, and older persons gain mutual support and benefits.

AoA made six new awards in FY 1991 to Area Agencies on Aging to collaborate with community organizations to establish Volunteer Senior Aide programs. AoA has provided support to the National Council on the Aging (Washington, D.C.) to provide technical assistance in implementing their demonstrations. A summary evaluation of outcomes will be designed by the Mid-America Regional Council Commission on Aging (Kansas City, MO), one of the Volunteer Senior Aides demonstration grantees. Demonstration grants were awarded to:

The Los Angeles County Area agency on Aging (Los Angeles, CA), in collaboration with Jewish Family Services of Los Angeles and Huntington Memorial Hospital of Pasadena, for senior volunteer aides to provide assistance to low-income and minority families, including grandparents raising disabled or ill grandchildren, who may have been adversely affected by their mothers' drug abuse and/or have Acquired Immune Deficiency Syndrome (AIDS).

The CrossRoads of Iowa Area Agency on Aging (Des Moines, IA), in collaboration with the Easter Seal Society of Iowa, to recruit and train senior volunteers from primarily rural area to serve disabled or ill children to reduce their risk of placement outside the home.

The Mid-America Regional Council Area Agency on Aging (Kansas City, MO), in collaboration with the Children's Mercy Hospital (Kansas City, MO), and the University of Missouri-Kansas City University Affiliated Program for Developmental Disabilities, to expand upon an existing Family Friends Program which will assist families in the inner-city area of Kansas City and will develop replicable models benefiting special needs populations.

The Region IV Area Agency on Aging (St. Joseph, MI), in collaboration with the local Foster Grandparents Program, to place volunteer senior aides with families of children who have special physical or emotional needs, with the expectation that the volunteer becomes a standard component of the families treatment plans.

The Philadelphia Corporation for Aging (Philadelphia, PA), in cooperation with Temple University's Center for Intergenerational Learning and Institute on Disabilities, will recruit, train, and supervise volunteer aides to provide in-home support to disabled children and their families.

The County of Riverside Office on Aging (Riverside, CA) will link older volunteers with at-risk families of disabled/chronically ill children, to increase the availability of respite care and domestic management training for caregiving families.

IV. CONTINUED TITLE IV PROGRAM INITIATIVES

During FY 1991, AoA continued to manage activities initiated and supported under the Commissioner's Annual Statement of Goals for Fiscal Year 1990. The eight (8) policy goals were issued as a challenge to the Aging Network to serve the current generation of Older Americans more effectively while building a long range capacity to respond to the dramatic increases in the older population projected for the coming decades. Most project grants funded under the FY 1990 Title Discretionary Grants Program Announcement that implemented the Commissioner's goals were awarded late in the fiscal year and were operational during FY 1991. Some received continuation support during FY 1991 and will continue to be active during the next fiscal year.

A. MANPOWER DEVELOPMENT

Initiatives under this goal are to increase awareness of, and promote action to relieve, the critical manpower needs in the field of aging, with particular attention to the need for an adequate supply of trained personnel to care for older persons at home, in the community and in nursing homes.

1. NATIONAL LEADERSHIP INSTITUTE

The National Leadership Institute on Aging directed by the University of Colorado (Denver, CO) provides quality leadership development opportunities to executives in the aging network in order to improve their leadership capabilities. These executives include representatives from State and Area Agencies on Aging, tribal units, national aging organizations, other national organizations and private and nonprofit organizations that have the responsibility for the development and implementation of service systems for older persons and their caregivers. The Institute increases the capacity of these individuals to better design and deliver strategic and innovative services and stimulate changes in the system in order to enhance family and community-based care.

The primary method by which the Institute meets its objectives is through the implementation of residential leadership programs. These intensive programs are generally 10 days in length, and are led by expert faculty. The Institute has, thus far, implemented 10 such programs, with additional ones being planned for the future. Attendees have come from almost every State in the Union, the success of these programs has been well documented, and the Institute has achieved national recognition. In addition, the Institute provides technical assistance and consultation to aging network agencies and others, nationwide relevant to the development of plans for enhancing the leadership skills and abilities of their executives.

2. NATIVE AMERICAN LEADERSHIP INSTITUTE

During FY 1991, Three Feathers Associates (Norman, OK) conducted its third annual Native American Leadership Institute program for training Title VI Older Americans Act project directors. In addition to training 36 new participants, the Institute revised its existing curriculum, and using computer technology, developed a self-instruction set of manuals. Other activities included, dissemination of a Title VI Leadership Society poster and Institute logo; development of a strategy for identification and recognition of outstanding Title VI directors throughout the Indian and national network; and production of three 60 minute audio teleconferences and their dissemination to a large number of Title VI Directors. The project final report in progress will include evaluative data of the Institute 3 years of operation and recommendations for meeting continuing training needs of the Title VI network.

3. FACULTY AND PROGRAM DEVELOPMENT

During FY 1991, AoA continued to work with project grants made in FY 1990 for faculty and program development grants to institutions of higher education for gerontological training and development. These projects were awarded in recognition of the need for highly trained faculty members to help students understand the aging process, gain sensitivity about the needs and values of older persons, and to discover ways for our society to meet the challenges of an aging society. The nine projects funded in FY 1990 and operation during FY 1991 were:

The University of the District of Columbia (Washington, DC) is establishing the first Masters degree program in gerontology at an Historically Black College and University and in the DC area.

San Francisco State University (San Francisco, CA) is addressing the need for community college faculty training and curriculum development with an emphasis on multi-cultural aging.

The University of Massachusetts (Boston, MA) is linking an established gerontology program with an institution without a gerontology program to establish a program at the latter and access the essential target population for the established institution.

Baylor College of Medicine (Houston, TX) is providing a gerontological nursing faculty development and incorporate aging content into the curriculum.

Tougaloo College (Tougaloo, MS) is combining research, faculty development and information dissemination in the interest of improving the cadre of trained faculty in health promotion in the State.

Illinois State University (Normal, IL) is developing faculty expertise regarding the needs of the low-income and minority elderly living in rural communities.

Florida Agricultural and Mechanical University (Tallahassee, FL) is conducting training in gerontology and geriatrics for faculty at historically black colleges and universities, formulate curricula guidelines to phase into regular program, and develop new curricula in aging for professional majors.

The Association of Schools and Colleges of Optometry (Rockville, MD) is addressing recognized needs in optometric education and clinical services to the elderly by developing a competency-based module on managing low-income and minority elderly patients.

The University of Kansas (Lawrence, KS) is, through a collaborative effort, provide gerontological program and faculty development of American Indian tribal colleges throughout the United States.

4. EDUCATION TO PREPARE FOR AN AGING SOCIETY

In FY 1990, AoA awarded grants to four national aging organizations and four universities to develop public education programs about aging for individuals and groups whose members hold leadership positions in such areas as business and labor, public administration and politics, media, professional, and religious organizations and academia. An additional grant was awarded to a national aging organization in FY 1991. The goal of these projects is to improve the public image of older persons and increases public awareness about the roles that American institutions can play to enhance the experience of aging today and in the future.

The National Association of Area Agencies on Aging (Washington, D.C.) in conjunction with the National Association of Counties (Washington, D.C.) is developing two videos and a guidebook to assist Area Agencies on Aging to educate county officials about aging issues.

North Carolina Central University (Durham, NC) is conducting 11 workshops for State and local elected officials across the country targeted at assisting minority elected officials to become more aware of the importance of aging issues and how to deal with them at the local level.

The University of Mississippi Medical Center (Jackson, MS) is working with the Southern Governor's Association to educate Governors and their staffs about aging issues in 17 States. Each State will be developing their own action plan for aging in the twenty-first century.

The American Bar Association Commission on Legal Problems for the Elderly (Washington, D.C.) has developed a video and accompanying materials designed to educate employers and employees about the Age Discrimination in Employment Act. The goals of the project are to influence employer attitudes and perceptions about older adults and to encourage them to hire and retain older workers.

West Virginia University (Morgantown, WV) is conducting a statewide project to increase the clergy's knowledge about aging and aging resources in the local community. One of the outcomes is to create a permanent linkage between the church and the Area Agencies on Aging.

The University of California at Los Angeles (Los Angeles, CA) is providing education for media professionals such as television and movie directors, writers and producers. The project is designed to encourage more sensitive media portrayals of older adults and improve public perceptions of the elderly.

The American Society on Aging (San Francisco, CA) has developed a multifaceted public education program designed to challenge ageist stereotypes and

recommend approaches for local changes by educating nontraditional aging providers such as executives of professional and trade associations, unions, volunteer organizations, and religious and civic groups.

The National Council on the Aging (Washington, D.C.) They are conducting intensive seminars with members of 20 nonaging national civic, fraternal, denominational, and professional associations about the social and economic implications of an aging society and is encouraging them to undertake initiatives in their local communities.

The National Interfaith Coalition on Aging, recently merged with the National Council on the Aging (Washington, D.C.) is conducting four regional focus groups with different religious denominations to identify strategies, programs and resources for training and preparing clergy and laity working with congregations to help meet the needs of their aging members.

5. EMPLOYMENT OF GERONTOLOGY GRADUATES

Over the past 10 years, AoA has supported a series of studies exploring the relationship between gerontology career training and jobs which require application of specialized knowledge of aging. In 1991 the report—Determining the Impact of Gerontology Preparation on Personnel In the Aging Network: A National Survey—was completed based on an FY 1989 research grant to the Association for Gerontology in Higher Education (Washington, D.C.) in collaboration with the Andrus Gerontology Center, University of Southern California (Los Angeles, CA). The report is based on a 1990 national survey of professionals in State and Area Agencies on Aging and looks at general education requirements, job positions, job task areas, and training in aging experiences of job incumbents.

In FY 1990, AoA funded the Association for Gerontology in Higher Education (Washington, D.C.) to work with Association for Gerontology and Human Development (Washington, D.C.) to conduct a special survey of gerontology programs in historically black colleges and universities. Finding from this survey and the one conducted in 1990 will be analyzed under this grant by the Andrus Gerontology Center, University of Southern California (Los Angeles, CA), to prepare guidance for modification and creation of instructional programs which more accurately reflect competence needed in Aging Network jobs.

B. TARGETING OF RESOURCES

Projects and activities initiated under this goal and supported in FY 1990 with project grants have been developing and implementing new strategies for more effectively targeting resources and programs on the needs of the most vulnerable older persons, with special emphasis on low-income minority elderly.

1. MINORITY MANAGEMENT TRAINING PROGRAM

In FY 1990 AoA funded seven projects under its continuing Minority Management Traineeship Program. This program focuses on assisting highly motivated minority professionals, preferably with undergraduate or advanced degrees and several years of prior experience in the field of aging. The projects operational in FY 1991, were evenly divided between academic institutions and national minority aging organization as follows:

Lincoln University (Philadelphia, PA) has been recruiting, training, and supervising predominately black students who are placed in aging agencies within Philadelphia and its environs.

Hunter College of the City University of New York (New York, NY) has been implementing a model for training and employment of minorities which includes professional social work education with specialized content in aging and intensive field work with public and voluntary agencies throughout New York City.

North Carolina Central University (Durham, NC) has been helping minority trainees make the transition from staff level to managerial positions in the aging network and place graduate students enrolled in a Masters of Public Administration Program in intern positions in collaboration with two other historically black universities.

Boston College (Chestnut Hill, MA) has been assisting minority trainees in advancing in management of elder services with financial aid, training, counseling, and placement activities with service delivery agencies in the Greater Boston vicinity.

The National Hispanic Council on Aging (Washington, D.C.) has been supporting a mentorship program for professionals who have been placed in Aging Net-

work agencies, including exposure to a series of educational enrichment activities and participation in specific culture/language program involving Latino elderly.

The Asociacion Nacional Pro Personas Mayores (Los Angeles, CA) has been giving administrative/management training to Hispanic trainees and with host agencies, supervising 6-month placements in positions where culturally sensitive social services for Hispanic elders are needed.

The National black Caucus and Center on Black Aged, Inc., has been recruiting black graduates with degrees in gerontology, nursing home administration, and related fields for placement in long term care and nursing home facilities and assisting them in meeting pre-licensure requirements including preparation for taking State licensure examinations.

2. NATIONAL MINORITY ORGANIZATIONS

Five national minority organizations who were awarded grants in FY 1990 to develop outreach efforts that target older persons potentially eligible for Supplemental Security Income (SSI) benefits received continuation awards in FY 1991 for a second and final project year. The projects enjoy strong support from the Social Security Administration (SSA) and its district office managers.

The National Caucus and Center on Black Aged, Inc. (Washington, D.C.) has been conducting training in nine states for certification of older persons as entitlement workers together with training of their supervisors from host agencies. Conduct of the training in nine States has resulted in an increased number of enrollments and back payments to potentially eligibility older persons who were previously overlooked.

The Asociacion Nacional Pro Personas Mayores (Los Angeles, CA) has been concentrating efforts on stimulating linkages among local entitlement agencies, the aging network, and public and private community members do better coordinate services to older Hispanics. Stimulation of these linkages has already contributed to increased enrollment of Hispanic seniors in the cities of Miami, Los Angeles, and Philadelphia.

The National Pacific Asian Resource Center on Aging (Seattle, WA) has been reaching older Pacific/Asians through use of training videos and community meetings towards increasing awareness and utilization of Supplemental Security Income, Medicaid, and Older Americans Act Services.

The National Indian Council on Aging (Albuquerque, NM) is collaborating with the national Resource Center on Minority Populations at the University of California at San Diego and the American Association of Retired Persons to increase access to services and entitlement programs in Native American tribes. The project has nearly doubled the number of tribes participating (16) since its inception.

The National Hispanic Council on Aging (Washington, D.C.) has been combining outreach activities for health promotion and disease prevention with access to entitlement programs for Latino elderly in four sites where they have chapters and affiliates. The project has established a National Advisory Committee to disseminate information about project activities.

3. IMPROVED TARGETING TO NATIVE AMERICAN ELDERS

Three Indian Area Agencies on Aging were funded in FY 1990 to demonstrate new strategies to improve targeting of Federal, State tribal, and private resources to Native American elderly. Project efforts are directed toward advocacy activities, training programs, making an impact on Federal, State, and local policies, and providing needed services to the Indian elderly. In FY 1991, the following activities occurred with these Area Agencies on Aging:

The Lewis-Mason Thurston Area Agency on Aging (Olympia, WA) has been working with four Indian tribal organizations (Squaxin Island, Skokomish, Nisqually, and consolidated tribes of the Chelhalis Reservation) in implementing a comprehensive screening and referral of elders for services available on and outside of their reservations.

The Minnesota Chippewa Tribe (Cass Lake, MN) has been working with the Minnesota Indian Council of Elders to develop advocacy activities with 12 reservation groups, conduct leadership training, identify unmet needs in public hearings, and conduct direct advocacy casework when called upon.

The InterTribal Council of Arizona, Inc. (Phoenix), representing (19) tribes throughout the State, has been developing a plan and model program for targeting resources to the Indian elderly which involves coordination of existing re-

sources available on reservations through State and Federal programs with testing of several strategies involving the Pascua Yagui Tribe.

4. MINORITY ELDERLY AGENDAS

Seven national aging and minority organizations received AoA continuation awards in late FY 1990 for the second year of their projects to develop or enhance their knowledge of minority aging issues and to broaden their capacity to deal with the concerns of low income minority elderly on an on-going basis. During FY 1991, these organizations continued to be engaged in the following activities:

The National Council of La Raza (Washington, D.C.) has developed a guide to help Hispanic groups become involved in elderly services, a manual to help aging organizations improve planning and service programs for Hispanics, and two resource guides.

The National Caucus and Center on Black Aged (Washington, D.C.) in collaboration with the American Association of Retired Persons (Washington, D.C.), has been conducting activities in six cities to increase participation of black elderly in Older American Act programs and working together to stimulate low-income minority elderly agendas in other national organizations.

The Gerontological Society of America (Washington, D.C.) has been strengthening its organization agenda to minority concerns by increasing the number of sessions on minority aging issues at its annual conference, creating a society-wide task force, giving presentations at national organizations on minority issues, conducting student and faculty research workshops, and placing two minority post-doctoral fellows in community-based agencies serving minority elderly in Memphis, TN and El Paso, TX).

The National Association of State Units on Aging (Washington, D.C.) has been promoting use of State minority task forces through development of a technical assistance manual and establishment of eight pilot projects (North Dakota, Washington, Pennsylvania, Ohio, West Virginia, Georgia, Kentucky, and Rhode Island).

The American Society on Aging (San Francisco, CA) has been facilitating national visibility of minority elderly concerns by developing program guides and a facilitator's handbook for use in convening eight leadership roundtables in various locations throughout the United States, implementing a National Fellows/Mentors Program, and conducting a minority membership campaign.

The National Association of Area Agencies on Aging (Washington, D.C.) created a Minority Targeting Technical Assistance Center for its member agencies and is developing and testing a self-assessment and training package on improving Area Agencies on Aging responsiveness to minority issues.

The National Indian Council on Aging (Albuquerque, NM) has been convening focus groups and holding discussions at meetings of national organizations as a prelude to convening national meetings to prepare an agenda for Indian elders at the 1993 White House Conference on Aging and encouraging formation of Indian Councils on Aging in several States and a multi-State region.

5. ALTERNATIVES TO GUARDIANSHIP

In FY 1990 three projects were funded to demonstrate alternatives to legal guardianship of older adults who have difficulty managing themselves independently because of loss of function, illness, or other disability.

The Legal Counsel of the American Association of Retired Persons (Washington, D.C.) is completing a demonstration, in two States, of a model of early intervention services performed by trained volunteers which includes representative payee services, bill payer services, and development of self-help materials on money management.

The American Bar Association (Chicago, IL) has completed testing, in nine States, a national training module on guardianship alternatives and support services aimed at the aging network and a range of professionals, including social and legal services providers and, after revision, will disseminate it to State Agencies on Aging and State Protection and Advocacy Agencies.

The Center for Social Gerontology (Ann Arbor, MI), working in collaboration with the University of Missouri-Kansas City and the Older Women's League, is expanding knowledge about guardianship by conducting a national survey of State practices related to the imposition and provision of guardianship services and the numbers and characteristics of adults affected by guardianship; and is studying the feasibility of developing a computerized expert systems file.

6. RESOURCE CENTER ON ELDER ABUSE

The National Aging Resource Center on Elder Abuse (NARCEA) was established in 1989 as a collaborative effort by the American Public Welfare Association (Washington, D.C.) working together with the University of Delaware (Wilmington, DE) and the National Association of State Units on Aging (Washington, D.C.). NARCEA serves as a resource of information, data, and technical expertise on elder abuse to State and local aging and adult protective service personnel, to other professionals and practitioners concerned with elder abuse, and to the public.

During FY 1991, the Center's technical assistance, training, dissemination, and short-term research activities focused on enhancement of knowledge and skills in elder abuse program development, agency management and service delivery, along with an increase in public awareness concerning the problem. NARCEA provided training and technical assistance on financial exploitation and coordination between law enforcement and protective services via two teleconferences; convened several conferences, distributed ten issues of NARCEA EXCHANGE (the Center's quarterly newsletter), and filled over 1,000 requests for information and search services of CANE (the Clearinghouse on Abuse and Neglect of the Elderly) and the NARCEA phoneline. The Center completed seven new technical assistance materials, including—Elder Abuse Video Resources: A Guide for Training and Public Education, and Elder Abuse: Questions and Answers. . . . and four major research papers—National Elder Abuse Research Agenda, A Compendium of Reports from NARCEA's Small Research Grants Program, and "Elder Abuse in the United States." an Issue Paper.

7. RESOURCE CENTER ON MINORITY AGING POPULATIONS

The National Resource Center on Minority Aging Populations was established in FY 1989 as a collaborative effort between San Diego State University (San Diego, CA) and the University of Southern California (Los Angeles, CA). The Center was established to serve as a national focal point for technical assistance, training, information dissemination, and short-term research. Its efforts continue to support States, communities, educational institutions, professionals in the field, and the public in understanding and responding to issues affecting minority elderly.

In FY 1991, the Center continued to provide technical assistance to State Agencies on Aging via teleconferences, workshops, and written materials. Four registries of resources for minority aging populations were published as well as additional bibliographies and mini-reports. Six issues of the *Minority Aging Exchange Newsletter* were disseminated. A number of Government documents were analyzed for AoA to provide information regarding the status of elderly American Indians. The Center continued to collaborate with a number of national aging organizations on conferences, publications and resource sharing. The Center will develop a pamphlet of available products produced through AoA-funded grants and of relevance to the minority aging community.

8. RESOURCE CENTER FOR RURAL ELDERLY

The National Resource Center for Rural Elderly was established in FY 1989 at the University of Missouri (Kansas City, MO). Its technical assistance, training, information dissemination, and short-term research and developmental efforts are supporting States, communities, educational institutions, professionals in the field and the public in understanding and responding to issues affecting the rural elderly. The Center has been serving as a national focal point for the identification of best-practice programs and services for the rural elderly in three primary focus areas (access/transportation, health/care coordination, and housing/assisted living alternatives).

During FY 1991 the Center conducted workshops in the areas of access/transportation, needs assessment, housing alternatives, and caregiver support. The Center also developed manuals on: in-home services, mental health, health programs, housing, challenges and solutions to providing services, and funding raising and advocacy. These products have been or will be disseminated early in FY 1992. The Center published a bi-monthly newsletter entitled "The Rural Networker" and responded to ad hoc technical assistance requests from State Agencies on Aging on a variety of issues related to the rural elderly.

C. PROMOTION AND ENHANCEMENT OF COMMUNITY BASED SERVICE SYSTEMS

During FY 1991, as in previous years, AoA continued support for building and strengthening comprehensive and coordinated community service systems to insure that such services are available, accessible, and acceptable to older persons.

1. NATIONAL AGING RESOURCE CENTERS ON LONG TERM CARE

Six National Aging Resource Centers on Long-Term Care were established in FY 1988 with 3-year cooperative agreement awards to provide training and technical information to State and Area Agencies on Aging to assist them in developing community-based long-term care service systems. Each Center has focused on a specific set of topics within the broad scope of long-term care. Three topics have become focal points for collection of information and research results, production and dissemination of issue papers, development of resource manuals and training materials, and the conduct of conferences, workshops, and meeting presentations. Fiscal year 1990 funding support was provided for the third and final year of Center operations.

A. STATE MANAGEMENT OF COMMUNITY-BASED CARE SYSTEMS

This National Aging Resource Center, operated by the National Association of State Units on Aging (Washington, D.C.), has assisted State Units on Aging in their efforts to design and manage community based care systems by addressing policy, operation, and management issues facing States as they reform their systems to enhance community care options available to older people. Issues areas which it has provided technical assistance to States on have included case management, targeting criteria, State and local administrative structures, financing mechanisms, quality assurance, supportive in-home services, and linkage of long-term care systems to systems delivering acute, primary, and institutional care.

During FY 1991, the Center conducted a major study of community based long-term care programs which analyzes similarities and differences in State approaches to long-term care program development (Comprehensive State Community Care Program Profiles). Other Center reports disseminated during this period were—State Approaches to Strategic Planning for Community Care Systems, Community Care Laws Enacted by States in 1989 and 1990, Addressing the Long Term Care Needs of Minority Older Persons: A Policy Resource Book, and State Medicaid Waiver Program Characteristics. In addition to presentations at a numbers of national, regional, and State conferences, the Center conducted a national symposium on quality assurance in State community care programs.

B. NATIONAL AGING RESOURCE CENTER: LONG TERM CARE

The Bigel Institute at Brandeis University (Waltham, MA) has been directing the National Aging Resource Center: Long Term Care since FY 1989. It has provided training and technical assistance to State and Area Agencies on Aging in the areas of community-based long-term care, public and private partnerships, and cultural diversity and other emerging issues related to the long-term care workforce.

In FY 1991 the Center presented at national and State training events, provided intensive technical assistance to State and Area Agencies on Aging, conducted cultural diversity focus groups and surveys in a number of cities, planned and implemented the Administration on Aging's (AoA) National Invitational Meeting on Home Care Personnel Issues, and prepared for AoA a report to Congress on the Workforce to Serve the Vulnerable Elderly. Publications released by the Center in year three included: Issues in Quality Assurance: Topical Overviews; Private Sector Initiatives in Long Term Care: Topical Overviews; Cultural Diversity and the Aging Network Workbook; Proceedings from the AoA National Invitational Meeting on Home Care Personnel Issues; and A Report on the Workforce to Serve the Vulnerable Elderly.

C. THE LONG-TERM CARE NATIONAL RESOURCE CENTER AT UCLA/USC

This National Resource Center has been a collaborative effort between the Division of Geriatric Medicine and Gerontology at the University of California, Los Angeles, and the Andrus Gerontology Center at the University of Southern California (Los Angeles, CA). The Center has focused on five long-term topics in the area of housing and health systems development, including: home repair and modification, assisted-housing alternatives, respite care, discharge planning, and geriatric assessment.

In year three, the Center conducted two national teleconferences with State and Area Agencies and health provider organizations on developments in hospital discharge planning and strengthening relationships between the Aging Network and health care providers. Along with Fannie Mae and the American Association for Retired Persons, the Center organized and ran a major conference on senior housing. It published a series of technical briefs on nursing home discharges, hospital discharge planning, and comprehensive geriatric assessments, and pending Federal

housing legislation affecting the elderly. The following manuals were completed: Best Practices in Assisted Living, Volunteer Respite Care for the Elderly, National Directory of Home Modification/Repair Programs, Guidebook on Home Modification and Repair Programs, and Assisted Living Innovations in Designing, Management, and Financing.

D. THE NATIONAL RESOURCE CENTER ON ALZHEIMER'S DISEASE

The National Resource Center on Alzheimer's Disease managed by the Suncoast Gerontology Center, University of South Florida (Tampa, FL), has focused on activities and programs affecting the care of Alzheimer's patients and their family caregivers. In year three it planned and convened in Washington, D.C., a symposium for planners, administrators, and legislative staff on the impact of a growing number of Alzheimer's Disease patients over the next decade. Papers and discussion on the magnitude of the problem, family caregiver concerns, and an approach to planning services will be published in early FY 1992.

During FY 1991, the Center summarized its research, technical assistance, and training activities in a series of publications which have been or were near completion by the end of the year. These included: four training curriculum guides—Long Term Care of the Alzheimer Patient, Care to the Caregivers in Alzheimer's Disease, Ethnic Culture and Alzheimer's Disease, and Socio-cultural Factors Affecting Elderly Ethnic Minority; a research report and manual on special facilities for patients in advanced stages of Alzheimer's Disease—Special Care for Alzheimer's Disease Patients: An Exploratory Study of Dementia Special Care Units and Guidelines for Dementia Special Care Units for Memory Impaired Older Adults; and two technical assistance papers—Alzheimer's Disease: A Service Matrix for Patients and Family Caregivers and Non-Pharmacological Therapeutic Interventions for Dementia Patients.

E. LONG-TERM CARE DECISIONS CENTER

The DECISIONS Center established at the School of Public Health, University of Minnesota (Minneapolis, MN), has focused on the development of case management systems and the ethics of management and caregiving of long-term care services. In year three, the Center completed a series of working conferences on issue papers related to its mission, holding conferences on family care giving, assessment of value, and preferences of clients, ethics and case management, and the rights of elderly to assume risk in choosing formal care options. Support was given to five fellows nominated by State Agency on Aging Directors from West Virginia, Louisiana, New Mexico, Idaho, and Texas, to work on planning, improving or implementing community-based service delivery networks.

Based on working papers discussed in a conference in year two, the Center completed a series of reviews of assessment instruments most often used by professionals to determine eligibility for public entitlement or to diagnosis, treat, and rehabilitate loss or deterioration of functions in the elderly. Reviews completed in year three were Assessment of Subjective Well-Being and Client Satisfaction, Multidimensional Assessment in Case Management, Cognitive Assessment, and Assessment of Caregiver Burden. Also completed was a training curriculum for nursing home staff on the importance and place of values and ethics in caring for residents. The major publication produced in FY 1991 was Ethics and Long-Term Care: A Catalogue of Issues.

F. HEARTLAND CENTER ON AGING, DISABILITY, AND LONG-TERM CARE

The Heartland Center sponsored by the National Center for Senior Living, South Bend, IN, and located at the School of Public and Environmental Affairs, Indiana University at Indianapolis, has focused on the use of needs assessment and data analysis by State and Area Agencies on Aging to document the unmet needs of the elderly in their jurisdictions. In its third year, the Center gave priority to expanding and revising earlier work of the center which reported on the search and examination of national and State data bases with survey information on service provision and quality of life of older adults. It continued its program of bringing staff of State Agencies on Aging to the Center for technical assistance and training on survey research development and data analysis, including practitioners from Iowa, New Mexico, and Idaho.

The major Center publication was "Unmet Needs: The Challenge for Planning and Targeting Resources" which describes different types of needs assessments and an approach for combining them to maximize planning efforts with limited available resources. Other publications include, Targeting Individuals and High Risk In-

stitutionalizing, Determinants of Health Behavior Change in Elders, The Economic Cost of Caring: Impact on Burden, Graying of Black American, Retirement in America—Examination of Finds from the Supplement on Aging Survey, Use of the Annual Housing Survey for Study of Elderly Americans, Survey of Income and Program Participation as a Planning Tool, ADLs and Eligibility for Services—Implications for Minorities, Migrating Dollars: Elders, Taxes, and Local Budgets.

2. HOUSING AND SUPPORTIVE SERVICES

Nine projects designed to expand the availability of supportive services to moderate and low-income frail elderly in federally supported facilities were awarded in FY 1990 and received continuation funds in FY 1991. Five grantees are State housing finance agencies while four others are State Agencies on Aging. During the initial year of many of these projects, statewide advisory committees were formed, designed to bring the aging, housing, and other service networks together.

Collaborative relationships have resulted in formal agreements between the sponsoring agency and other agencies (ex. Office on Aging and the Housing Authorities). Agreements cover such activities as development of functional assessment tools and survey instruments to assess the functioning and needs of seniors in federally assisted housing, training of housing managers and staff including preparation of video tapes and directories of services have been developed along with "how to" manuals; and selection of pilot to sites develop programs to address supportive service needs in communities. The project will be sharing their successes of the first year of operation of the projects in a national meeting scheduled to be held early in FY 1992. The on-going projects are:

New York State Office for the Aging (Albany, NY) is facilitating access to community services for residents of up to 15 community State assisted rental housing programs.

Colorado Housing and Finance Authority (Denver, CO) is coordinating an array of support services to sight impaired, low-income and minority elderly residents in State financed Section 8 housing throughout the State.

Connecticut Housing Finance Authority (Rocky Hill, CT) is assisting private management companies who hire social service staff to work directly with elderly residents in six housing developments.

Ohio Department of Aging (Columbus, OH) is developing a model supportive services program for demonstration at two sites with statewide training for housing managers on us of an assessment screening tool to determine the service needs of frail elderly residents.

Vermont Housing Finance Agency (Burlington, VT) is establishing a five region, statewide, supportive service system for elderly in subsidized housing, including seniors living in over 84 State subsidized housing developments.

New Hampshire Housing Finance Authority (Bedford, NH) is collaborating with the State Department of Human Services to develop a referral, advocacy, and training program for housing managers and supporting three pilot projects addressing supportive service needs.

Minnesota Board on Aging (St. Paul, MN) is developing training materials and offering financial incentives to communities to hire senior housing on-site coordinators who will help elderly tenants arrange for supportive services.

New Jersey Housing and Mortgage Finance Agency (Trenton, NJ) is developing a referral network and services resources directory with education of housing managers, families and tenants on the need for and availability of supportive services.

Arkansas Department of Human Services (Little Rock, AR) is forming a statewide commission of housing and aging professionals to promote support service resources and the training of housing unit managers to be more responsive to the needs of elderly residents.

3. NUTRITION SERVICES

Three grantees continue project activities during FY 1991 to identify, develop, and disseminate innovative approaches for improving nutrition programs and services for the elderly.

The National Association of Nutrition and Aging Services Programs (Washington, D.C.) is working with the National Association of State Units on Aging (Washington, D.C.) to develop a manual of innovative best practices which feature models for delivery of nutrition services to Eldercare target groups and to develop self-assessment instruments and materials to improve planning and service agency evaluation and planning of their nutrition programs.

The Phoenix Systems, Inc. (Sioux Falls, SD) is generating private sector involvement and cost sharing in the nutrition services program and incorporating its experience in conducting marketing/needs assessment studies in development of a technical assistance manual for nutrition service planners and site managers.

The National Association of Meal Programs (Grand Rapids, MI) is working with agribusiness organizations in conducting a feasibility study of a frozen/fresh meal system for serving isolated and homebound elderly which uses USDA commodities and other food sources that will be cost effective while maintaining menu choice, nutrient value, and food safety.

4. LEGAL ASSISTANCE

Legal assistance is one of the services required under Title III of the Older Americans Act, the following Title IV projects help to increase the quality, effectiveness, and efficiency of legal assistance provided under Title III.

A. NATIONAL LEGAL ASSISTANCE SUPPORT PROGRAM

Legal assistance providers under Title III, to be effective, need the types of support available to other lawyers. AoA funded continuation grant awards to eight national organizations to provide this support to State and Area Agencies on Aging, legal services developers, as well as legal assistance providers. These projects help assure that effective and efficient legal assistance is available to older people, especially those in the greatest economic and social need. A special emphasis is to increase the coordination of legal and other services provider under Title III. These projects are:

The National Senior Citizens Law Center (Washington, D.C.) is providing technical, assistance, training, and consultation to legal assistance providers funded under the Older American Act on Federal beneficiary programs and legal areas such as nursing home law, pension and retiree health care, protective services, and age discrimination.

The Commission on Legal Problems of the Elderly of the American Bar Association (Washington, D.C.) is strengthening State legal assistance systems by linking and integrating them with other segments of the legal and judicial service systems and providing assistance and training in legislative tracking, model legal assistance standards, and private bar involvement.

The Mental Health Law Project (Washington, D.C.) provides training and technical assistance on legal matters relating to mental disabilities and protection available to older persons confined in nursing homes and psychiatric hospitals including case and nonlitigation consultation.

The Pension Rights Center (Washington, D.C.) has developed a National Lawyers Network which includes lawyers in every State willing to assist older people receiving pensions; established pilot pension assistance projects in New York City, Philadelphia, Atlanta, Chicago, and San Francisco; and gives technical assistance to State legal assistance service systems and the private bar.

The Legal Counsel for Elderly of the American Association of Retired Persons (Washington, D.C.) uses a curricula it developed to train experts in various areas of legal assistance; supplements State systems of legal assistance with support of Statewide volunteer networks and local volunteer program by sponsoring training workshops on protective services; and provides technical assistance on the formation and operation of legal hotlines.

The National Clearinghouse for Legal Services (Chicago, IL) provides a full range of legal information and research services to State Legal Services Developers and Title II funded legal service providers based on its computer-assisted legal research data base and publishes Clearinghouse Review as a service to all Title II legal assistance providers.

The Center for Social Gerontology (Ann Arbor, MI) provides in-depth support, often on-site, to individual States to strengthen their leadership capacity and service delivery system capability to provide accessible and efficient legal assistance.

The National Bar Association (Washington, D.C.) works with State Agencies on Aging to help them meet the legal assistance needs of low income, minority elderly through linkage and referral to members of minority bar associations, publications, and sponsorship of orientation and training programs.

B. STATEWIDE LEGAL HOTLINES

In FY 1990, AoA, under a memorandum of understanding with the American Association of Retired Persons (Washington, D.C.) began a special initiative to expand the availability of legal hotlines for older people. In 1985 AoA funded a Title IV Demonstration by AARP in Pittsburgh, PA to develop and test a legal hotline for older people. This model worked effectively and was expanded to the entire State. Later, AARP with some AoA assistance provided seed money to develop hotlines in the District of Columbia, Florida, and Texas. Under the new agreement, AARP agreed to provide seed money for two additional hotlines (Ohio and Michigan were selected) and AoA for three new hotlines. When the new hotlines are operational, nearly one-third of the Nation's older people will have free access to legal advice.

The current legal hotlines are receiving over 20,000 calls per year. When an older person with a legal problem calls the hotline specially trained lawyers provide step-by-step advice on how to resolve the problem. Issues which cannot be resolved in one call are referred to local legal aid specialists or to a panel of attorneys in private practice who agree to charge reduced fees. More than 81 percent of callers' legal questions can be resolved during the initial phone call, according to a 5-year evaluation of the existing hotlines. The three AoA projects funded in FY 1991 are:

The Maine hotline, operated by the Legal Services for the Elderly (Augusta, MA) will be serving as the primary intake mechanism for their statewide network of legal assistance offices.

The Arizona hotline, operated by Southern Arizona Legal Aid (Tucson, AZ), will test new strategies for outreach to the State's Native American and Hispanic populations.

In New Mexico, the hotline is will be operated by the State Bar of New Mexico (Albuquerque, NM) to expand and improve their current pro bono program.

C. TRIBAL ENTITLEMENT PROJECT

In FY 1990, AoA funded the Washington State Indian Council on Aging (Wapato, WA) to examine barriers faced by tribal elders to receiving Federal program entitlement and improve access through information and advocacy. The project is documenting barriers and gaps in resources for financial, medical, food, and in-home health services through development of case studies of elders living on reservations in five States (Washington, Oregon, Idaho, Utah, and Montana).

D. REPRESENTATIVE PAYEES

AoA entered into a cooperative agreement with the Social Security Administration (SSA) (Baltimore, MD) to jointly fund the National Criminal Justice Foundation (Washington, D.C.) to develop and implement demonstration programs in 10 States for using State criminal history records to conduct background checks on potential representative payees. The representative payee program is a system which gives an individual authority to conduct a limited set of financial transactions on behalf of an older person who has a diminished capacity to handle their own personal affairs, in this instance to receive and spend, on behalf of the older person, their Social Security check. The representative payee system is less costly and more restricted in its oversight than court appointment of a guardian.

Under the terms of the agreement between AoA and the Social Security Administration (SSA), each agency will alternate award of financial support to the grantee. Initial funding awarded in FY 1990 was provided by SSA with early FY 1992 support to be given by AoA.

5. INFORMATION AND REFERRAL SERVICES

Information and referral (I&R) service which links persons in need with appropriate service to meet or alleviate that need has been a priority of Older Americans Act Programs since 1973 when the reauthorization amendments required State and Area Agencies on Aging to establish them within convenient access to all older persons. Since the mandate was given, AoA has worked with a number of organizations to establish policies and develop technical assistance handbooks promoting I&R services. Although much has been accomplished, the dramatic increases in the older population and introduction of new technologies, AoA recognized that improvements in such areas as training, technical assistance, and standards of operation (last revised in 1983), were required.

A. ELDERCARE LOCATOR

In FY 1990, a 3-year grant was awarded to the National Association for Area Agencies on Aging (Washington, D.C.) to establish a national locator service. The Eldercare Locator will feature a national 800 number through which callers can locate the name, address, and the information and referral telephone number for an Area Agency on Aging anywhere in the country. A major effort of the project is to develop financial support for the locator system from the private sector especially corporate sponsorship. Anticipated results of this locator system include:

- greater recognition of the need for and existence of eldercare and the at-risk elderly;
- greater national recognition of existing community I&R systems through a national toll-free telephone number providing callers with referrals to local Area Agencies on Aging and/or their I&R providers;
- a consistent and uniform identity for the Aging Network as a result of a public information campaign announcing the locator service; and
- reduction of the difficulties faced by long-distance caregivers in linking their older parent or relative with appropriate supportive services.

B. NATIONAL INFORMATION AND REFERRAL CENTER

In FY 1990, a 3-year project a grant was awarded to the National Association of State Units on Aging (Washington, D.C.) who will work with the National Association of Area Agencies on Aging (Washington, D.C.) and the Alliance of Information and Referral Systems (Bethesda, MD) to establish a National Information and Referral Center to enhance the capacity of State aging Information and Referral systems.

The Center will assist I&R providers to participate in Eldercare Coalition by contributing their knowledge of aging needs and establish standards for Information and Referral systems which help older people. The Center will promote I&R systems improvement as a priority with the Aging Network, in part by establish a national information exchange to provide access to existing I&R training materials, experts and best practices and providing training and technical assistance. It will also help individual States and Area Agencies on Aging facilitate the development of I&R systems improvement plans.

C. AOA/ACTION PROJECTS

AoA and ACTION jointly funded 11 grants in FY 1990 to support a 3-year demonstration program to expand the number of Senior Companion volunteers providing in-home services to the frail, homebound elderly. This joint program effort is designed to combine public and private resources to support and sustain the work of ACTION's Senior Companion Programs, leading toward establishing their self-sufficiency in the long term.

The 11 State Agencies on Aging receiving project support—Vermont, Pennsylvania, Virginia, Florida, Georgia, Kentucky, Wisconsin, Minnesota, New Mexico, Missouri, and Nevada—in collaboration with selected Area Agencies on Aging and local Senior Companion Programs, have designated a total of 19 community demonstration programs, one site for the demonstration program for a total of 19 sites. Some sites have added as many as five additional senior volunteers to their programs in the early states of their demonstrations. ACTION and AoA are cooperatively undertaking an evaluation of the program's effectiveness and applicability nationwide.

D. PREVENTION AND ALTERNATIVES TO INSTITUTIONAL CARE

A significant number of older persons, a proportion that increases with age, are residents of institutions that provide health care and personal services. While institutional care is appropriate for many persons suffering functional loss due to advanced age, chronic disease, or in need of intensive rehabilitation to recover from an acute health problem; it is not always the least restrictive and most affordable environment for persons who can be maintained in their home with assistance of family and friends or in-home and community volunteer and professional services. Therefore, an important goal of AoA is to promote the recognition of the importance, and the development, of preventive, in-home and community-based supportive services as vital components for the continuum of care.

1. STATE LONG-TERM CARE PROJECTS

In FY 1990 nine grants were awarded to assist State Agencies on Aging develop collaborative efforts with other State agencies, Area Agencies on Aging, and others to plan and implement specific improvements in State long-term care systems.

These grants, which were continued in FY 1991 for the second year of their 2-year project periods, were made to the following State agencies:

Older Alaskans Commission (Juneau, AL) is carrying out interagency planning efforts for "non-Medicaid" eligible populations to complement a Medicaid-only plan required by the State legislature.

Arizona Department of Economic Security/Aging and Adult Administration (Phoenix, AZ) is demonstrating approaches to linking Older Americans Act and Medicaid systems in 13 rural counties.

Colorado Department of Social Services/Medical Services (Denver, CO) is linking State aging, social service, Medicaid and vocational rehabilitation agencies to address statewide case management practices.

Florida Department of Health and Rehabilitation Services/Aging and Adult Services (Tallahassee, FL) is demonstrating the extent to which enhanced hospital based preadmission screening and improved aging network and institutional linkages may affect community placements of older persons.

Hawaii Office on Aging (Honolulu, HA) is developing, in conjunction with key State agencies, Area Agencies on Aging and other segments of the aging network, a comprehensive long-term care plan required by the State legislature.

Missouri Department of Social Services/Division on Aging (Jefferson City, MI) is implementing a comprehensive long-term care planning process in cooperation with Area Agencies on Aging and other State agencies.

Ohio Department on Aging (Columbus, OH) is developing an interagency plan for home and community based care to provide a policy framework for recent "Eldercare" initiative approved by the State legislature.

The West Virginia Commission on Aging (Charleston, WV) is planning several State long-term care system improvements in cooperation with other State agencies and Area Agencies on Aging.

The Wisconsin Department of Health and Social Services/Bureau of Aging is demonstrating the extent to which more effective case management and improved linkages between community based and acute care providers will improve services for older persons.

2. SERVICES FOR RURAL AND LOW-INCOME ELDERLY

In FY 1990, AoA funded the second year of six demonstrations of improving access of rural and low-income elderly to community and in-home services. These projects were operational during FY 1991 and are completing project evaluations in preparation for final reports to be issued in late 1991. These project are:

Bureau of Maine's Elderly (August, ME) in collaboration with five Area Agencies on Aging has been conducting a series of activities to improve health care access for the elderly including recruitment and training of volunteers for outreach and counseling in remote areas.

Nebraska Department on Aging (Lincoln, NE) in collaboration with the National Council on Aging (Washington, D.C.) working with four rural senior centers to adapt the existing manual—Comprehensive Service Delivery Through Senior Centers and Other Community Focal Points—has produced a training manual and video on its model for involving community leaders in developing rural centers.

The Senior Services Division of the Oregon State Department of Human Services (Salem, OR) has through a series of 13 mini-grants been conducting a series of public education and training events to increase recruitment, employment, and training of long-term care paraprofessionals and producing technical assistance guides for replication.

The Idaho Office on Aging (Boise, ID) has supported mobilization of community leaders to identify service needs and generate support for establishment and operation of adult day care facilities and produced a training manual on organizing community councils.

Tennessee Hospital Association (Nashville, TN) has linked three rural hospitals with local senior centers and Area Agencies on Aging to facilitate hospital discharge planning and conduct health promotion education for its outpatients.

Florida Agricultural and Mechanical University (Tallahassee, FL) has been conducting a series of educational programs throughout the State with pharmacists on the case, prevention and treatment of diabetic retinopathy and its impact on high risk groups especially low-income blacks, Native Americans, and Hispanics.

3. HEALTH PROMOTION

Health promotion activities for older people increase the possibility that they can improve their health status, reduce personal health care expenditures, and enhance the quality of their life. AoA has engaged in a variety of health promotional activities since the early 1980's which have been sustained, in part, from its continuing relationship with the U.S. Public Health Service and its series of publications on the topic. Activities supported by AoA that were on-going in FY 1991 continued that legacy, and as indicated above, will be on-going in the National Eldercare Campaign.

A. NATIONAL RESOURCE CENTER ON HEALTH PROMOTION AND AGING

In October 1988, AoA entered into a 3-year cooperative agreement with the American Association of Retired Persons (Washington, D.C.) to establish a National Resource Center on Health Promotion and Aging. The principal mission of the Center on Health Promotion has been to serve the State Units on Aging by providing training and technical assistance as well as providing information and other resources to agencies and organizations who are interested in health promotion with older adults.

In FY 1990, the Resource Center continued to provide technical assistance to State Units on Aging, build its resource library and publish a bi-monthly newsletter which is distributed to 14,000 health and aging practitioners and other persons. In addition, the Center provided on site technical assistance to eight States and one Federal region to assist them in developing a specific health promotion plans or projects; and continued dissemination of video and print materials describing minority health promotion activities. In January 1991, The Center planned and hosted a meeting of 25 AoA health promotion projects, including 10 projects funded in FY 1989 with historically black colleges and universities and 15 other funded in either FY 1989 or 1990. They also assisted 9 regional offices in sponsoring regional health promotion conferences.

B. PROTOTYPE HEALTH PROMOTION PROJECTS

In keeping with Section 422(a)(2) of the 1987 Older Americans Act Amendments, five projects were funded in FY 1990 designed to develop prototype models for educating older persons, their caregivers, and families about hearing impairments, promoting early intervention strategies for the prevention, detection and treatment of diabetes, and breast cancer. The projects are collaborative efforts among institutions of higher education, State Units on Aging, Area Agencies on Aging, and appropriate other public and private agencies.

University of Alabama (Birmingham, AL) has designed a project to train nutrition project staff to identify older persons with hearing problems and refer them for care. The project is targeting rural, low income, and minority older persons.

University of Arizona (Tucson, AR) is developing a cultural sensitive nutrition program for Pascua Yaqui Indians with non-insulin dependent diabetes including therapeutic diabetic meals at senior centers and programs for exercise and weight reduction.

Boston University (Boston, MA) is developing a statewide diabetes education initiative aimed at service providers and minority elderly. The project is focusing on prevention and detection of symptoms, and treatment and life style modifications.

Lincoln University (Lincoln, MO) is involving 10 historically black colleges and universities in a diabetic screening, referral, and counseling program.

Case Western Reserve University (Cleveland, OH) is conducting an experimental program working with two organizations sponsoring senior centers which involve training and use of volunteer peer educators to promote breast cancer screening among minority elderly.

C. NATIONAL OSTEOPOROSIS FOUNDATION

In FY 1990, under a grant from AoA, the National Osteoporosis Foundation developed a national media education program entitled the "Bone Wise" Media Campaign. The purpose of the campaign was to educate older persons, their caregivers and other informal and formal caregivers about the signs and symptoms of osteoporosis, how to prevent it and how to live with it. Secretary Louis W. Sullivan appeared on two public service announcements that were aired nationwide and a kit of spe-

cially developed materials was offered to persons who followed up for this information. Over 4,000 inquiries for materials were received in one 3-month period.

D. NATIONAL COUNCIL ON PATIENT INFORMATION AND EDUCATION

The Administration on Aging has again supported "Talk About Prescription Month" and sent copies of the National Council on Patient Information and Education's materials to the network of State and Area Agencies on Aging. The theme for this year's "Talk About Prescriptions" Month is "Everyone Wins When You Talk." It focuses attention on the benefits of improved communication for patients, health care providers, and caregivers whenever medicines are prescribed and dispensed. During fiscal year 1991, AoA sent out 14,000 copies of the National Council's Newsletter. In addition, AoA provided a grant of \$120,000 to the National Council to organize a "Brown Bag" medicine review program to encourage older consumers to put all their medicines in a bag and take them to their health professional for a personalized medicine review.

E. TELEVISION DOCUMENTARY

ETNET, Inc., the nonprofit arm of CWI Productions, Inc. is developing a 1-hour television documentary to educate the public on positive findings about aging, particularly in the areas of physical, personal, and social fitness. A sequel to their successful documentary "Our Nations Health, . . . A Question of Choice," produced by CWI Inc., this video will show that proper health promotion can make a significant difference in bringing the lives of older persons to their fullest potential. The program will be aired on public broadcasting stations nationwide and will be made available to the aging network. This production will be supported by two private sector sponsors as well as AoA.

F. INTERAGENCY ACTIVITIES

The Administration on Aging is participating with the rest of the Department of Health and Human Services in a nationwide campaign to improve personal health by encouraging positive and preventive health behaviors. The campaign is titled "you can make a difference—a HEALTHY difference!" The topics that the campaign will focus on include immunization, drinking, especially among teenagers, nutrition, exercise, and smoking cessation. For those topics geared toward younger populations, the AoA has urged older persons to work with their children and grandchildren to adhere to these public health advisories. Beginning in June 1991, and over the course of the next 6 months, thousands of agencies, organizations, and departmental grantees will be receiving materials from the Department of Health and Human Services which the Department hopes that the recipients will make available to their target populations, in this case, older persons in their programs and communities.

A new Memorandum of Understanding (MOU) was reached between AoA and the Office of Disease Prevention and Health Promotion of the U.S. Public Health Service (PHS). The current MOU will update three previous ones effective since 1984 and transfer PHS leadership of the initiative from the Office of the Surgeon General to the Office of Disease Prevention and Health Promotion. The MOU provides for AoA to assume a leadership role in strengthening State and Community Eldercare Coalitions and assisting them, as appropriate, to undertake activities directed at achievement of the year 2000 health objectives. It also calls for involvement of the National Resource Center on Health Promotion and Aging and its successor, the National Eldercare Institute on Health Promotion and Aging in the provision of training and technical assistance for the conduct of health promotion activities at the State and local level. Under the agreement, a working group will be established co-chaired by AoA and U.S. Public Health Service with interagency participation. In addition to information exchange and public education, the committee will be jointly select Healthy People 2000 priority areas that will be used to guide PHS and AoA health promotion program activities in each year of this agreement.

4. SMALL BUSINESS INNOVATIVE RESEARCH PROGRAM

In FY 1991, support was given for Phase II contracts under the Small Business Innovative Research Program, an activity coordinated by the U.S. Small Business Administration. Phase I contracts were awarded by AoA in FY 1990. These contracts address the continued applications of technology to meet the needs of older persons for devices which assist them to perform tasks of daily living. Projects supported are as follows:

Gil-Mart Enterprises (San Antonio, TX) for the continued development of an affordable personal hygiene system which will enable the disabled elderly to maintain personal cleanliness independently of the caregiver.

Triangle Research and Development Corporation (Research Triangle Park, NC) for the construction of a unique air-mattress system for the prevention of decubiti and the enhancement of blood circulation.

Gibson-Hunt Associates (Washington, D.C.) for a detailed plan for educating professionals on the need for self-help devices for the elderly will continue with a national, live interactive teleconference on independence of the elderly and a video edited from the teleconference, along with study materials for publication and dissemination.

5. IMPROVING SERVICES TO OLDER PERSONS WITH DEVELOPMENTAL DISABILITIES

Increasing numbers of older persons with developmental disabilities (DD) are aging as they live at home with their families. The capacity of their aging parents to continue as caregivers is at risk. Effective coordination and delivery of services to these individuals is urgently needed. To address these needs, AoA awarded four grants, beginning in FY 1990, for projects to be carried out jointly by State agencies on Aging and State DD Planning Councils to develop aging/DD State and local planning linkages. These projects were continued through FY 1991. The Administration on Developmental Disabilities (ADD) is co-funding three of these projects. These collaborative models are demonstrating and fostering the replication of improved delivery of services to older person with DD and their aging family caregivers:

The New York State Developmental Disabilities Planning Council (Albany, NY) and State Office for the Aging are producing and disseminating technical "how-to" manuals based on cross-network integration and assisting other States with implementation.

The Missouri Planning Council for Developmental Disabilities Jefferson City, MO) and the University of Missouri-Kansas City's Interdisciplinary Training Center on Gerontology and Developmental Disabilities are establishing: a centralized resource center for older persons with DD, their caregivers' and professionals; a caregivers network and protective services hotline; and an ongoing mechanism for statewide planning and collaboration.

The Wisconsin Council on Developmental Disabilities (Madison, WI) and the Wisconsin Bureau on Aging, in collaboration with the Waisman Center on Mental Retardation and Human Development at the University of Wisconsin, are focusing on: case-finding, identifying the unserved and undeserved, particularly in rural areas; targeting older American Indians with developmental disabilities; and lifespan planning.

The Virginia Department for the Aging (Richmond, VA) and the Virginia board for the Rights of the Disabled, in collaboration with the Virginia Center on Aging and the Virginia Institute for Developmental Disabilities, are addressing regulatory, program, budgetary, and other barriers to services, developing a core of 250 cross-trained personnel, and holding a National teleconference on aging and DD.

6. IMPROVING STATE CAPACITY TO DETERMINE NEEDS OF CAREGIVERS

AoA awarded a field-initiated research project grant in FY 1990 to the South Carolina Commission on Aging (Columbia, SC) to work with the Institute of Public Affairs, University of South Carolina (Columbia, and the Heartland Center on Aging, University of Indiana (Indianapolis, IN) to develop and administer a State survey of family caregivers of the elderly on their unmet needs. The public policy implications of the survey are currently being analyzed and the result will be released in a report in late 1991.

7. GUIDE TO MODEL AREA AGENCIES ON AGING CAREGIVER SUPPORT PROGRAMS

The National Association of Area Agencies on Aging (Washington, D.C.) was awarded a grant in FY 1990 to compile a compendium of successful activities and programs collected from the 672 Area Agencies on Aging that plan and administer service programs under the Older American Act. The manual—Information for Care Givers of the Elderly—includes profiles of training, information, and referral services, family caregiver support, and direct service programs for older persons. It is being disseminated to State and Area Agencies on Aging and national organizations.

E. PUBLIC PRIVATE PARTNERSHIPS

The rapid rise in the number of older persons living in the United States has for a number of years exceeded the growth in public expenditures for Federal, State, and local programs offering support for in-home, community, and to a lesser extent, institutional services. The challenge of the changing demographics have increased awareness within both the public and private sectors of the need to stimulate expansion of services and resources for older persons. AoA has been engaged for a number of years in promoting public/private partnerships to meet this challenge, including a number of activities conducted during FY 1991.

1. BUSINESS AND HEALTH

The Washington Business Group on Health (Washington, D.C.), received a demonstration grant in FY 1990 to develop public private partnerships in four sites: Seattle, Atlanta, Chicago, and Boston; and to develop and disseminate training and technical assistance materials for the aging network on how to work with the private sector, particularly the business community. It is continuing to develop training and technical assistance materials both generic to the public private partnership area and dealing with the specific content areas of eldercare, older worker employment, health promotion, and volunteerism.

The Washington Business Group on Health assisted AoA with the implementation of the first Business and Aging Leadership Awards Program. Over 165 companies were nominated for initiatives they had undertaken in four categories: Employment and Training, Work/Family Issues, Health Promotion, and Volunteerism/Community Initiatives. In a ceremony held in May 1991, the Commissioner and Secretary Sullivan gave awards to 23 companies in recognition of their accomplishments, described in a booklet prepared by the grantee and available from them upon request.

2. NATIONAL ENERGY AND AGING CONSORTIUM

The National Energy and Aging Consortium (Washington, D.C.) is a coalition of national public and private sector organizations concerned about the energy related needs of the elderly. Energy related needs are defined in the broadest terms to include such issues as housing, assistive devices in the home, and low-income energy assistance. AoA continues to take an active role in the Consortium and serves as a member of the Steering Committee. A major focus of the Consortium is the development of State energy and aging consortia. To date, 14 such consortia have been established. Technical Assistance materials (kits) developed under a FY 1990 grant to the University of Oklahoma (Norman, OK) are now available. In-service training sessions have been held. A January 1992 Dissemination Conference is being planned. By early 1992, a national journal will be selected to carry these useful and successful accomplishments about these energy saving efforts for the elderly.

3. COMING OF AGE IN AMERICA

AoA provided grant support in FY 1990 to the Coming of Age in America Association (Seattle, WA) for the planning phase of Coming of Age in America, a national traveling exhibit that celebrates aging. When completed the exhibit, developed in association with the Smithsonian Institution and the American Association of Retired Persons, will visit shopping centers, libraries, museums, and community centers across the country. The project will help build a positive image of aging, provide information for younger people that will help them age positively, and give older people information that will help them access local services, helping them to remain as independent as possible.

4. NATIONAL MEALS-ON-WHEELS FOUNDATION

In FY 1990 The National Meals-on-Wheels Foundation (Grand Rapids, MI) was awarded a grant by AoA to develop private sector support to expand the senior meals. The grantee has developed a corporate volunteer program in the Minnesota twin cities area. In addition the Foundation has completed two training sessions for expanding corporate and community partnerships. A national television quality Public Service Announcement featuring a national spokes person is being produced. This project encourages local meal providers to move toward greater self-sufficiency and encourages funding from sources other than traditional Federal and State grants.

5. CORPORATE ELDERCARE

A grant was made to the National Association of Area Agencies on Aging (Washington, D.C.) in FY 1990 in collaboration with the National Aging Resource Center on Long Term Care at Brandeis University (Waltham, MA) to research the Aging Network's response to the needs of employed caregivers. The survey has been completed, and the analysis is being completed by the Bigel Institute at Brandeis University. The findings, soon to be published, will provide the first source of information on the extent to which the Aging Network is actually providing eldercare services to employers. Information gained from this study will be developed into technical assistance offered to State Units on Aging and Area Agencies on Aging. In addition, program development gaps will be identified that will help state and local policymakers be more responsive to the needs of the community.

6. OLDER WORKERS

The National Governors Association (Washington, D.C.) in cooperation with the National Association of State Units on Aging (Washington, D.C.) and the National Alliance for Business (Washington, D.C.) have been trying to improve the hiring and retention of older workers through development and testing of a multimedia training curriculum for State and local job developers. It is currently in the process of developing a policy options handbook which will be completed and disseminated in FY 1992.

7. DEVELOPING NEW PUBLIC/PRIVATE SECTOR PARTNERSHIPS

In FY 1990 AoA made 13 awards to State and Area Agencies on Aging to generate new resources or to expand existing resources to meet the needs of older persons by supporting the development of new or expanded public/private partnerships. Support is being sought to enhance or sustain community agencies and programs in areas of senior employment and training, work site Eldercare programs, adult day, medication management, and rural health services. The current grant to the Washington Business Group on Health (Washington, D.C.) was supplemented to give these project technical assistance.

Sonoma County Area Agency on Aging, Santa Rosa, CA is expanding its Older Worker Network by establishing a senior mentor program which will match retired volunteers with the job seekers over age 55 who have basic educational deficiencies and language barriers.

Fairfax County Area Agency on Aging (Fairfax, VA) is adding private sector job placements to its existing public sector job placement program of its Senior Training Employment Program and developing written and audio-visual materials documenting supervision, data collection, and evaluation instruments used in operating the program.

New York City Department for the Aging (New York, NY) with support from the International Business Machines Corporation is expanding an existing senior employment services program by offering underemployed or unemployed older workers basic computer and office skills training and placement.

Philadelphia Corporation for Aging (Philadelphia, PA) is developing a coalition of local companies and the Chamber of Commerce to assist older workers and retirees with the goal of increasing corporate involvement in issues and in programs of the aging work force and marketplace.

Suffolk County Department for the Aging (Hauppauge, NY) has formed a partnership of corporations and unions to develop and operate two elderly social model day care centers with intergenerational programming.

Westchester County Office for the Aging (White Plains, NY) is working with the International Business Machine Corporation to establish a tax exempt, non-profit organization to raise, revenues; and to develop and operate a service delivery model for the rural portion of the county that includes support services and transportation for isolated home-bound frail elderly.

Southern Maine Area Agency on Aging (Portland, ME) is enrolling 10 area businesses to support an Eldercare Specialist to expand the capacity of private sector employers to support working caregivers.

Maryland Office on Aging (Baltimore, MD) is adding to its Senior Reach Partners Program, a coalition of corporate and private nonprofit organizations, a family care network program to assist employees and retirees in caring for acutely or chronically ill family members.

Jefferson County Office of Senior Citizens' Activities (Birmingham, Al) is working with a coalition of academic, corporate, voluntary, and government or-

ganizations to demonstrate a medication management systems for elderly residents of 44 county domiciliary houses.

Los Angeles Department of Aging (Los Angeles, CA) has formed a coalition of corporate and public organizations to create an Eldercare program which will provide training, referral, and structuring of employee benefit packages as services to employees caring for frail elderly.

Delaware Department of Health and Social Services (New Castle, DE) is working with the State Chamber of Commerce to develop information packages, employees seminars, and employer workshops to increase access of employees and their families to community and in-home services.

Puerto Rico Governor's Office of Elderly Affairs (San Juan, PR) and Smith Line and French Pharmaceutical are collaborating to offer health evaluation and referral services in eight rural area and give supportive services to health promotion self-help groups.

County of Orange Area Agency on Aging (Santa Ana, CA) is revitalizing a nonprofit foundation devoted to supporting nutrition and supportive services by assisting fund solicitation and public education.

8. USE OF PUBLIC TELEVISION

Under a FY 1990 grant to QEX Communications, Inc., formally Metropolitan Pittsburgh Public Broadcasting (Pittsburgh, PA) is collaborating with the National Association for State Units on Aging (Washington, DC), the Pennsylvania Department on Aging (Harrisburg, PA) produced 260 half-hour television programs for QEX Channel 16. The series educates older people about managing their health care. Twelve episodes were broadcast via satellite to the network of 260 plus public broadcast stations for airing in their viewing area. An additional six half-hour segments will be broadcast nationally beginning December 1992, in close-captioned, English, and Spanish versions.

F. STRENGTHENING THE FAMILY AND GENERATIONAL BONDING

It has long been recognized that most care for frail older persons who need at least some assistance in conducting their personal care and ordinary functions of daily living is provided by family members. The national trend toward smaller nuclear and consequently extended families and the increase in single parent households has combined with increasing longevity to threaten sustainment of existing levels of informal care, much less increase their provision. To increase understanding of societal implications of aging, with particular attention to the development and implementation of strategies for strengthening the family and interdependence of generations, AoA continued support for a variety of intergenerational activity funded and continued during FY 1991.

1. MODEL INTERGENERATIONAL PROJECTS

Twelve regional project grants were awarded in FY 1990 to disseminate best practices in intergenerational programming and to develop models in intergenerational day care, after school care, youth and parent drug counseling, and family mentorship.

Elder Services of Merrimack Valley, Inc. (Lawrence, MA) is developing a telephone reassurance program involving seniors and school age "latch key" children.

The National Council on the Aging (Washington, DC) is gathering and disseminating information on intergenerational child care programs to assist Generations United, a coalition of nonprofit agencies involved with intergenerational program, to serve as a resource center assisting individuals interested in beginning intergenerational child care programs.

The University of Pittsburgh's Generations Together Program (Pittsburgh, PA) is facilitating partnerships between agencies with established intergenerational programs and agencies which have no programs but are committed to begin them.

The City of Oakland (Oakland, CA) is demonstrating an intergenerational program using graduate student volunteers to provide group support, counseling, and respite care of young children and elderly involved with or at risk of being involved with drug-related problems.

The National Urban League (New York, NY) is developing a stay-in-school program for children living in public housing project sites which matches students with older volunteers.

Aid to Imprisoned Mothers (Atlanta, GA) is documenting a program that uses family advocates to counseling and coordinate access to available resources for grandmothers who care for grandchildren during their daughter's imprisonment.

The Louisiana Geriatric Assessment Center (Baton Rouge, LA) is developing intergenerational day care programs for vulnerable elderly and underprivileged children which promote social interaction and communication skills.

The University of North Carolina (Greensboro, NC) is implementing a program for school-age "latch-key" children which involves volunteer older persons who like to interact with young children and are in need of social contact and stimulation.

The American Natives for Community Action (Flagstaff, AZ) has established an Elders Council and Intergenerational Forum to match elderly native Americans with children and families to teach traditional lifeways and promote respect between the generations.

Our Lady of Lourdes Medical Center (Camden, NJ) is implementing a program using older adults as parent models for pregnant or parenting teens that targets infants that are drug addicted, have AIDS, or are otherwise handicapped.

The New York City Board of Education (New York, NY) is linking a large intermediate school district with area senior citizen centers to develop a program involving seniors and school age "latch-key" children with such activities as tutoring, computer literacy, career counseling, and visits to the homebound.

The New York State Office for the Aging (Albany, NY) is training junior and senior high school aged children on how to provide informal support for an elderly person in their family or through volunteer service.

AOA/HEAD START PROGRAM

The Administration on Aging (AoA) and the Head Start Program of the Administration for Children, Youth, and Families agreed in 1990 to jointly fund 2-year projects demonstrating intergenerational volunteer opportunities for older Americans in program settings linking aging organizations and Head Start Agencies. Head Start Program grantees are paired with local agencies which use older volunteers in their own programs, and working together, recruit, train, and place older volunteers in such roles as family mentors, classroom aides, and program management assistants.

During FY 1991, each project is continuing recruitment and placement of older volunteers, and in most locations, expanding the variety of roles for volunteers and the number of sites where they work. Special attention is being given to documentation of procedures and practices used for possible replication in other Head Start Programs. Head Start Programs and their collaborating aging organizations are:

Hawkeye Area Community Action Program (Cedar Rapids, IA), Heritage Agency on Aging, and Retired Senior Volunteer Program of Lynn County;

Chautauqua Opportunities, Inc. (Mayville, NY), Chautauqua County Office for Aging, and Retired Senior Volunteer Program;

Coastal Community Action Program (Aberdeen, WA) and Grays Harbor Retired Senior Volunteer Program;

Bi-County Community Action Council, Inc. (Bemidji, MN) and Beltrami and Cass County Senior Citizen Councils on Aging;

Community Action Inc. of Hayes, Caldwell and Blanco Counties (San Marcos, TX) and American Association of Retired Persons (San Marcos, Blanco, and Lockhart Chapters);

Cen-Clear Child Services, Inc. (Philipsburg, PA) and Clearfield County Area Agency on Aging;

Central Nebraska Community Services, Inc. (Loup City, NE) and South Central and Northeast Nebraska Area Agencies on Aging;

Community Action Agency of Somerville, Inc. (Somerville, MA) and Somerville Council on Aging;

Mahube Community Council, Inc. (Detroit Lakes, MN) and Retired Senior Volunteer Program; and

Board of County Commissioners Hillsborough Head Start Department (Tampa, FL).

3. INTEGRATING AGING INTO THE PUBLIC SCHOOL CURRICULUM

AoA funded three State Education Agencies in FY 1990 to develop materials, design activities using older volunteers, and train teachers that infused aging into

the curricula of elementary and secondary school programs. Teacher training in prototype materials was conducted in all three projects during the summer of 1991 with the anticipation of their use in the 1991/92 school year. Projects are on-going as follows:

Connecticut State Department of Education (Hartford, CT) is infusing aging content into health, home economics, language arts, and social studies of secondary school students and producing resource guides for teachers, administrators, and guidance counselors.

Missouri Department of Elementary and Secondary Education (Jefferson City, MO) in collaboration with the Center for the Study of Aging at the University of Missouri (Jefferson City, MO) has prepared aging resource materials for use in grades 3, 7 and 10 and is currently pilot testing their use in schools throughout the State.

The Mississippi State Department of Education (Jackson, MS) has developed modules for grades 7 to 12 as an addendum to the new Mississippi Comprehensive Health Curriculum for Secondary Schools which teaches fundamental concepts of aging and in cooperation with State and Area Agencies on Aging is recruiting volunteers for classroom and extracurricular activities.

4. ALZHEIMER DISEASE PROGRAM ACTIVITIES

AoA is supporting three projects designed to help improve access to services by minority persons with Alzheimer's Disease and their family caregivers. Each project is focusing on a different minority group of older people, demonstrating innovative and effective ways to meet such persons special information needs. Each project will demonstrate and evaluate what information channels and dissemination techniques are appropriate for reaching specific minority audiences. Projects supported in FY 1990 and active during FY 1991 were:

Morehouse School of Medicine, Department of Community Health and Preventive Medicine (Atlanta, GA) to design and implement a model community-based information and service program for blacks with Alzheimer's Disease and their family caregivers.

Institute for Community Research (Hartford, CT) to develop and disseminate educational materials on Alzheimer's Disease for Puerto Rican elderly, their caregivers, and social and health service providers.

Hawaii Executive Office on Aging (Honolulu, HI) to develop, test, and evaluate a multilingual, multimedia, outreach campaign on information and support services for Alzheimer's patients and families of Japanese, Korean, Chinese, Filipino, Hawaiian, Samoan, and Southeast Asian ethnicity.

SOCIAL SECURITY ADMINISTRATION

PROGRAMS ADMINISTERED BY THE SOCIAL SECURITY ADMINISTRATION—FISCAL YEAR 1991

The Social Security Administration (SSA) administers the Federal old-age, survivors, and disability insurance (OASDI) program (title II of the Social Security Act). OASDI is the basic program in the United States that provides income to individuals and families when workers retire, become disabled, or die. The basic idea of the cash benefits program is that, while they are working, employees and their employers pay Social Security taxes; the self-employed also are taxed on their net earnings. Then, when earnings stop, or are reduced because of retirement in old-age, death, or disability, cash benefits are paid to partially replace the earnings that were lost. Traditionally, current taxes have largely been paid out in current benefits. Social Security taxes are deposited to the Social Security trust funds and are used only to pay Social Security benefits and administrative expenses of the program. Amounts not currently needed for these purposes are invested in interest bearing obligations of the United States. Thus current workers help to pay current benefits and, at the same time, build rights to future benefits.

SSA also administers the Supplemental Security Income (SSI) program for needy aged, blind, and disabled people (title XVI of the Social Security Act). SSI provides a federally financed floor of income for eligible individuals with limited income and resources. SSI benefits are financed from general revenues. In about 65 percent of the cases, SSI is reduced due to individuals having countable income from other sources, including Social Security benefits.

SSA shares responsibility for the black lung program with the Department of Labor. SSA is responsible, under the Federal Coal Mine Health and Safety Act, for payment of black lung benefits to coal miners and their families who applied for

those benefits prior to July 1973 and for payment of black lung benefits to certain survivors of miners.

Local Social Security offices process applications for entitlement to the Medicare program and assist individuals with questions concerning Medicare benefits. Overall Federal administrative responsibility for the Medicare program rests with the Health Care Financing Administration, HHS.

Following is a summary of beneficiary data and selected administrative activities for fiscal year 1992.

I. OASDI BENEFITS AND BENEFICIARIES

At the beginning of 1991, about 95 percent of all jobs were covered under the Social Security program. It is expected that, under the present law, 96 percent of the jobs will be covered by the end of the century.

At the end of September 1991, 40.4 million people were receiving monthly Social Security cash benefits, compared to 39.7 million in September 1990. Of these beneficiaries, 25.2 million were retired workers, 3.5 million were dependents of retired workers, 4.4 million were disabled workers and their dependents, 7.2 million were survivors of deceased workers and about 6,000 were persons receiving special benefits for uninsured individuals who reached age 72 some years ago ("Prouty payments")¹

The monthly amount of benefits paid for September 1991 was \$22.5 billion, compared to \$21 billion for September 1990. Of this amount, \$15.5 billion was paid to retired workers and their dependents, \$2.4 billion was paid to disabled workers and their dependents, \$4.6 billion was paid to survivors, and \$1 billion was paid to uninsured persons who reached age 72 in the past.¹

Retired workers received an average benefit for September 1991 of \$607 (up from \$570 in September 1990), and disabled workers received an average benefit of \$588 (up from \$556 in September 1990). Retired workers newly awarded Social Security benefits for September 1991 averaged \$578, while disabled workers received an average initial benefit of \$593.

During the 12 months ending September 1991, \$263 billion in Social Security cash benefits were paid, compared to \$243.3 billion for the same period last year. Of that total, retired workers and their dependents received \$182.2 billion, disabled workers and their dependents received \$26.9 billion, survivors received \$53.9 billion, and uninsured beneficiaries over age 72 received \$13 million.

Monthly Social Security benefits were increased by 5.4 percent for December 1990 (payable beginning January 1991) to reflect a corresponding increase in the Consumer Price Index (CPI).

Monthly Social Security benefits will be increased by 3.7 percent for December 1991 (payable beginning January 1992) to reflect a corresponding increase in the CPI.

II. SUPPLEMENTAL SECURITY INCOME BENEFITS AND BENEFICIARIES

January 1991, SSI payment levels (like Social Security benefits amounts) were automatically adjusted to reflect a 5.4 percent increase in the CPI. From January through December 1991, the maximum monthly Federal SSI payment level for an individual was \$407. The maximum monthly benefit for a married couple, both of whom were eligible for SSI, was \$610. In January 1992, these monthly rates will increase to \$422 for an individual and \$633 for a couple, to reflect a 3.7 percent increase in the CPI.

As of June 1991, 4.9 million aged, blind, or disabled people received Federal SSI or federally administered State supplementary payments. Of the 4.9 million recipients on the rolls during June 1991, about 2 million were aged 65 or older. Of the recipients aged 65 or older, about 609,000 were eligible to receive benefits based on blindness or disability. About 2.9 million recipients were blind or disabled and under age 65. During June 1991, Federal SSI benefits and federally administered State supplementary payments totaling a little over \$1.5 billion were paid.

For fiscal year 1991, an estimated \$17.4 billion in benefits (consisting of \$14.2 billion in Federal funds and \$3.2 billion in federally administered State supplementary payments) were paid.

¹ The cost of these special benefits for aged uninsured persons is financed from general revenues, not from the Social Security trust funds.

III. BLACK LUNG BENEFITS AND BENEFICIARIES

Although responsibility for new black lung miner claims shifted to the Department of Labor (DOL) in July 1973, SSA continues to pay black lung benefits to a significant, but gradually declining, number of miners and survivors. (While DOL administers new claims taken by SSA under part C of the Federal Coal Mine Health and Safety Act, SSA is still responsible for administering part B of the Act).

During September 1991, about 197,000 individuals (152,000 age 65 or older) received \$69 million in black lung benefits which were administered by the Social Security Administration. These benefits are financed from general revenues. Of these individuals, 42,000 miners received \$16 million, 110,000 widows received \$43 million, and 45,000 dependents and survivors received \$10 million. During fiscal year 1991 SSA administered black lung payments in the amount of \$847 million. About 42,000 miners and 110,000 widows and wives were age 65 or older.

Black lung benefits increased by 4.1 percent effective January 1991 due to an automatic general benefit increase adjustment under the law. The monthly payment to a coal miner disabled by black lung disease increased from \$371.80 to \$387.10. The monthly benefit for a miner or widow with one dependent increased from \$557.70 to \$580.60 and with two dependents from \$650.70 to \$677.40. The maximum monthly benefit payable when there are three or more dependents increased from \$743.60 to \$774.10.

IV. COMMUNICATION AND SERVICES

In 1991, SSA directed its public information efforts at both the 45 million beneficiaries and the 134 million workers currently paying into the system. SSA emphasized how the program works, the benefits and services available, and the financial soundness of Social Security.

In 1991, SSA completed the revision and redesign of all its public information brochures and pamphlets to make them easier to understand. SSA now has more than 120 publication and fact sheets for the public and/or beneficiaries. More than 40 are available in Spanish. Additionally in 1991, SSA developed 11 publications in Braille. All told, SSA produced more than 90 million print public information materials in 1991.

SSA also expanded its information link to external groups through the "Social Security Courier," a monthly camera-ready publication in English and Spanish sent to more than 14,000 nonprofit and intergovernmental organizations. SSA also continued its national convention program, especially with employer and employee groups, to emphasize the value of the Personal Earnings and Benefit Estimate Statement (PEBES) as a tool in a person's retirement planning.

In late FY 1991, SSA opened a headquarters Public Information Distribution Center to make more materials directly available to external groups and organizations.

SSA also produced a series of television and radio public service announcements, as well as special video news releases on specific agency initiatives, and distributed these to more than 700 television stations, and 2,500 radio stations.

Of special note is SSA's public information and outreach campaign to implement the *Zebley* Supreme Court decision. SSA worked directly with more than 150 national organizations to reach the 450,000 children denied or terminated from receiving supplemental security income (SSI) benefits since 1980. More than 150,000 posters in English and Spanish were placed in State and local government agencies and nonprofit organizations that provide services to children with disabilities. Follow-up evaluations of the *Zebley* video news release indicated a projected audience of nearly 5 million television viewers and 7 million radio listeners. The value of the air time given to *Zebley* public service announcements was estimated at more than \$1 million.

In late 1991, SSA also ran a special information campaign publicizing SSA's new 800 number (1-800-772-1213), which was effective October 1, 1991. All SSA major public information pamphlets were revised to include this new number. The revised leaflets also include information about qualified Medicare beneficiary provisions.

A disability information kit was piloted nationwide for medical and other health professionals interested in the disability program.

Each year, SSA offices across the country answer millions of Social Security inquiries. Among these are inquiries to the President, the Congress, the Secretary of Health and Human Service, and the Commissioner of Social Security. In FY 1991, priority inquiries directed to SSA headquarters totalled 87,807. The major subject categories were disability, supplemental security, income, and hearings and appeals. SSA also processed more than 7,500 Freedom of Information Act requests.

SSA continued efforts to counter misleading advertising under the guidelines of Section 1140 of the Social Security Act, which prohibits misuse of symbols, emblems, or names in reference to Social Security or Medicare.

OFFICE OF INSPECTOR GENERAL

INTRODUCTION

The mission of the Office of Inspector General (OIG) is to prevent and detect fraud, waste, and abuse in the Department of Health and Human Services (HHS) programs and to promote efficiency and economy in its operations. It is the Inspector General's responsibility to report to the Secretary and the Congress any deficiencies or problems relating to HHS programs and to recommend corrective action, where appropriate.

As a result of a congressional oversight initiative into disclosures of fraud and waste in Federal/State Medicaid and welfare programs, Public Law 94-505 was passed, creating the statutory Inspector General in HHS. Enacted in 1976 the law placed equal emphasis on the Inspector General's obligation to detect wrong-doing and to make recommendations for changes and improvements in HHS programs.

The OIG works in a coordinated, cooperative way with other departmental components to accomplish its mission, except when the Inspector General believes that such a relationship would compromise the integrity and independence of the office. Close working relationships are established with the Social Security Administration (SSA), the Health Care Financing Administration (HCFA), the Administration for Children and Families (ACF) and the Public Health Service (PHS) and with other major Federal agencies, such as the Department of Justice (DOJ) and the Government Accounting Office (GAO), to maximize resources devoted to common problems. Governmentwide problems are addressed with other government agencies through the President's Council on Integrity and Efficiency (PCIE).

The OIG is divided into three components: the Office of Audit Services (OAS), the Office of Investigations (OI), and the Office of Evaluations and Inspections (OEI). The OAS is responsible for conducting audit services for HHS and overseeing audit work done by others. This component also examines the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities.

The OI reviews and investigates all allegations of a potentially criminal, civil, or administrative nature involving HHS programs or beneficiaries. In addition, OI is responsible for imposing administrative sanctions, including civil monetary penalties, on health care providers participating in the Medicare and Medicaid programs. Also, OI monitors the State Medicaid Fraud Control Unit (SMFCU) program, which was created to improve detection and eliminate fraud in the State run Medicaid programs.

The OEI conducts evaluations and inspections of Department programs and operations. These are usually short-term studies designed to focus on issues of current interest to Department officials or Members of Congress which highlight a program's efficiency or effectiveness. The Immediate Office of the Inspector General is responsible for setting OIG policy and direction, handling budgetary and administrative functions, reviewing and developing legislative and regulatory proposals and carrying out public affairs and Congressional Liaison responsibilities.

These audit, inspection and investigative activities focus on:

- Seeking ways to improve fiscal controls in benefit payment processes;
- Seeking ways to enhance trust fund financial management and accounting operations;
- Identifying more efficient and economical improvements in programs, procurement and service delivery, including reviews of the appropriateness of Federal payments of services provided and for the quality of care received; and
- Reducing the incidence of fraud, waste, and abuse in the Department's programs and to the Department's beneficiaries.

ACTIVITIES

Over the past 5 years the OIG has obtained over \$29.3 billion in settlements, fines, restitutions, receivables, and savings from its activities and implementation of its recommendations. In fiscal year 1991 alone, these types of savings exceeded \$6.8 billion. In addition, a total of 1,343 individuals and entities were convicted for engaging in crimes against HHS programs or beneficiaries and 1,005 health care providers and suppliers or their employees were administratively sanctioned in fiscal year 1991.

In addition to audit and investigative work, the OIG reviewed 257 departmental draft regulations, commented on 347 legislative proposals and testified on 19 occasions before congressional committees.

Following, under the headings, Health Care, Social Security, and Administration on Aging, are examples of OIG reviews conducted in fiscal year 1991 that have substantial impact on the elderly:

HEALTH CARE

Financed by the Federal Hospital Insurance Trust Fund, fiscal year 1991 expenditures for Medicare part A are estimated to be in excess of \$68 billion to provide health care coverage for an estimated 34 million individuals. Medicare Part A (hospital insurance) provides, through direct payment for specific use, hospital insurance protection for covered services to persons 65 or older and to certain disabled persons.

Medicare Part B (supplementary medical insurance) provides, through direct payments for specific use, insurance protection against most of the costs of health care to persons 65 or older and certain disabled persons who elect this coverage. The services covered are medically necessary physician services, outpatient hospital services, outpatient physical therapy, speech pathology services, and certain other medical and health services. Financed by participants and general revenues, fiscal year 1991 expenditures for Part B are expected to exceed \$44 billion.

The financial impact of the prospective payment system on hospitals, the increases in Part B expenditures, the implementation of physician payment reforms and the Clinical Laboratory Improvement Act of 1988, medical effectiveness, and the cost implications of changes in health care technology and delivery are and will continue to be of particular interest to the OIG.

Reducing Medication Problems of the Elderly.—The OIG performed a scientific literature review and found evidence that at least 55 percent of the elderly do not comply with their medication regimens. Noncompliance with prescription medications can result in hospitalization and use of other medical resources. There are many interrelated reasons for noncompliant behavior. However, studies have shown that noncompliance can be improved through educational and behavioral intervention techniques, and that compliance improving programs have high benefit-to-cost ratios.

The report recommends ways that PHS, HCFA, and the Administration on Aging can target resources within their agencies to help improve medication compliance among the elderly. These agencies have concurred and are already taking several initiatives.

The Clinical Role of the Community Pharmacist.—Two OIG reports indicate that although there is strong evidence that clinical pharmacy services add value to patient care, such services are not widely provided in community settings. There are no clear standards of practice that are functional in nature, nor are there practical needs assessment models to evaluate individual patient need. The inspection resulted in a number of recommendations directed to the Public Health Service (PHS), HCFA, the American Pharmaceutical Association, the American Association of Colleges of Pharmacy, and State governments. The recommendation directed to PHS calls for it to develop a strategy, individually and in collaboration with HCFA, to reduce barriers to providing clinical pharmacy services, particularly for ambulatory elderly patients. The recommendations focus on the problem of drug-related illness, which we believe is sufficiently critical to warrant a structured and comprehensive departmental response that combines the best efforts of HCFA and PHS.

State Regulation of Long-Term Care Insurance.—At the request of the Chairman of the House Subcommittee on Regulation, Business Opportunities, and Energy, the OIG examined the extent to which States conform with specific provisions of the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act and Model Regulation and describe State efforts to monitor and enforce their long-term care insurance laws. The inspection found that while all 50 States have long-term care insurance laws, only 17 States substantially meet both the NAIC model act and regulation minimum standards. It also found that (1) State complaint data are incomplete and inconclusive, and (2) States report little enforcement action against long-term care insurance companies and agents.

An additional report, "State Regulation of Long Term Care: State-by-State Analysis," compares each State's long-term care insurance laws and regulations and measures each State's conformity with the National Association of Insurance Commissioners Long-Term Care Insurance Model Act and Model Regulation standards.

Extent of Unrecovered Medicare Secondary Payer Funds.—In a series of reports, the OIG examined Medicare secondary payer activities. This MSP report found that

significant overpayments continue to occur in the MSP program. The report projected the loss to the Medicare program in 1988 to be over \$637 million with almost 90 percent due to unidentified insurance coverage of the working spouse of the Medicaid beneficiary. The savings from developing information to collect overpayments exceeds \$10 for every \$1 expended. We recommended various options that HCFA could use to prevent losses to the Medicare program due to unidentified primary payment sources. These include: Revising all Medicare claims forms to require spousal insurance information before claims are paid, and proposing legislation to require Medicare contractors to match their private health insurance records with Medicare files. We feel that the recommendations would help ensure that Medicare funds are protected and that private insurance, where it is available, pays for health care for the elderly.

New Jersey Medicare Beneficiary Satisfaction.—Following a change in carriers, the OIG surveyed the level of beneficiary satisfaction with the Medicare program in New Jersey. The study found that overall, New Jersey beneficiaries are satisfied with services. Specifically, they are satisfied with the claims processing, report that information is available when they need it, and like and use the toll-free, 800 number—although some problems were noted. In virtually all areas, the findings for New Jersey beneficiaries are comparable to those in early OIG reports for nationwide and Georgia beneficiaries.

Fraud Involving Durable Medical Equipment (DME).—Fraud in the DME industry is a continuing major concern, resulting in more than 90 convictions and civil monetary penalty settlements for the OIG over the past 4 years. Seat-lift mechanisms, transcutaneous electrical nerve stimulators, oxygen equipment, home dialysis systems and similar equipment are reimbursable by Medicare and Medicaid only if prescribed by physicians as medically necessary. Unscrupulous suppliers throughout the country circumvent this requirement through aggressive sales practices, tricking physicians into signing authorizations and even forging their signature. Some suppliers simply bill for items never delivered; others bill carriers in States which pay high Medicare reimbursement, regardless of where the sale took place.

Among the deceptive practices aimed at obtaining underserved Medicare and Medicaid reimbursement are "unbundling" (submitting separate claims for parts of single item, such as ostomy kits) and billing for dressing kits used to treat decubitus ulcers, or bedsores, as though they were surgical dressing kits. The latter abuse has reached proportions that prompted an alert to HCFA warning of the potential for abuse. Investigations by OIG have revealed instances where DME suppliers have billed for one to three kits a day for each nursing home patient for each bed sore, totaling \$1,200 to \$54,000 a month for a single patient. In one small northeastern nursing home, these claims for one patient amounted to \$100,000 in at least 1 month. Overall, Medicare payments for surgical dressing kits have increased more than 500 percent over the past 4 years.

The most effective way to prevent DME fraud and abuse is to remove regulatory and other loopholes which permit their occurrence. The HCFA is considering several preventive measures recommended by OIG. In the meantime, fraudulent practices increase health care costs and must be investigated individually and eliminated.

SOCIAL SECURITY

Fifty-six years ago, the Social Security Act established a national insurance system that would be financed through payroll taxes on workers and employers and would pay benefits to workers in their old age. The national Retirement Survivors and Disability Insurance (RSDI) program, popularly called Social Security, is the largest of the Social Security Administration (SSA) programs. In fiscal year 1991 SSA will pay almost \$263 billion in these benefits to 40 million beneficiaries. The program is financed almost entirely through payroll taxes paid by employees, their employers, and the self-employed. Benefits are distributed to retired and disabled workers, spouses, certain divorced spouses, children, and disabled children of retired and disabled workers. Benefits are also provided to widows and widowers, certain surviving divorced spouses, children, and dependent parents of deceased worker beneficiaries.

The Supplemental Security Income (SSI) program is a federally administered, means-tested assistance program that provides a nationally uniform, federally funded floor of income for the aged, blind, and disabled. Beginning January 1974, SSI replaced State and county-run assistance programs for the aged, blind and disabled that were funded by a mix of Federal and State money. Federalization of as-

sistance for these categories permitted the establishment of uniform eligibility criteria. In fiscal year 1991 SSA will pay SSI benefits in excess of \$14 billion.

Social Security Client Satisfaction: Fiscal Year 1991.—The OIG conducted its seventh survey to assess the level of client satisfaction with services provided by SSA. The survey found that satisfaction rates are high and remain unaffected by the staff reductions of the past 6 years. Eighty-three percent of the respondents reported service either “good” or “very good.” Likewise, respondents report receiving good service at field offices with 85 percent saying that the staff was courteous and nearly half reporting that their wait was shorter than expected. Nearly 80 percent of respondents prefer to telephone SSA. Although the understandability of mail from SSA fell 13 percent, fewer clients report having to contact SSA for assistance in understanding the mail.

ADMINISTRATION ON AGING (AOA)

Dissemination of Results of AOA's Discretionary Fund Projects.—The OIG conducted this inspection to examine dissemination of practices for discretionary fund projects funded by the Administration on Aging. We found that AOA relies primarily on grantees, whose capabilities vary widely, for dissemination of project results. We found that AOA does not adequately assess project outcomes to determine the utility of the information to others. We also found that AOA pursues a broad dissemination strategy with too limited resources. These dissemination activities do not assure that the results of the projects reach the aging organizations that can use them. In order to strengthen and better coordinate these efforts, we recommended that AOA establish and adequately fund a permanent function for disseminating the results of discretionary fund projects. As a result, AOA has established the Dissemination and Utilization Division which will be responsible for the overall coordination and implementation of the AOA dissemination and utilization of information in the field of aging.

Successful Ombudsman Programs.—The OIG conducted this inspection to determine the characteristics of successful State Long-Term Care Ombudsman programs. The inspection found that successful ombudsman programs are highly visible in both the aging community and the community-at-large, handle complaints expeditiously, and obtain adequate funding and support. Additionally, ombudsmen want more support, particularly the strengthening of the National Resource Center's role and increased Federal guidance. The report recommended that AOA support the State's efforts by: (1) developing model operational guidelines in areas of visibility and complaint resolution; (2) providing technical assistance regarding areas of concern to the ombudsman; (3) assuring that information about successful programs and effective techniques is systematically shared with all States with recommendations for implementation; and (4) strengthening the National Resource Center.

Ombudsman Output Measures.—The OIG also identified methods for measuring the success of ombudsman programs. We recommended that AOA develop a measurement or rating system which would provide a comparative basis for analyzing State programs, measuring progress, and targeting technical assistance.

Cost-Sharing for Older Americans.—The OIG found that cost-sharing recipients of the State-supported aging services they receive consider cost-sharing fair and appropriate and that the services are worth what they are asked to pay for them. State and local officials also support cost-sharing, and favor extending it to title III services. States with cost-sharing programs consider them effective and efficient.

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) serves as the principal advisor 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 which focus on the elderly and coordinates other activities which 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 on-going and completed HHS evaluations. In addition, the PIC database includes reports on ASPE Policy research studies, the Inspector General's program inspections and investigations done by the General Accounting Office, the Congressional Budget Office and the Office of Technology Assessment. Copies of final reports of the studies described in this report are available upon completion from PIC.

During 1991, staff of the Office of the Assistant Secretary for Planning and Evaluation undertook or participated in the following analytic and research activities which had a major focus on the elderly:

1. POLICY DEVELOPMENT—AGING

TASK FORCE ON ELDER ABUSE

ASPE and the Administration on Aging (AoA) chair the Secretary's Task Force on Elder Abuse that also includes the Health Care Financing Administration, the Public Health Service, and the Social Security Administration. The purpose of the Task Force is to develop a departmental strategy to promote the prevention and improved reporting, investigation and follow-up of elder abuse.

In 1991, the Secretary approved a comprehensive departmental action plan submitted by the Task Force. The plan recommended that the Department implement the following strategies: (1) Develop and fund a national research and data collection strategy on elder abuse, (2) develop and fund a technical assistance and training program on elder abuse, and (3) develop and promote targeted public education activities on elder abuse. The Task Force has begun to implement activities that will carry out these strategies.

TASK FORCE ON ALZHEIMER'S DISEASE

As a member of the DHHS Council on Alzheimer's Disease, each year ASPE helps prepare the annual report to the Congress on selected aspects of caring for persons with Alzheimer's disease. The report focuses on the Department's current and planned services research initiatives on Alzheimer's Disease.

FEDERAL INTERAGENCY FORUM ON AGING-RELATED STATISTICS

ASPE is a member of the Federal Interagency Forum on Aging-Related Statistics (The Forum). The Forum was established to encourage the development, collection, analysis, and dissemination of data on the older population. The Forum seeks to extend the use of limited resources among agencies through joint problem solving, identification of data gaps, and improvement of the statistical information bases on the older population that is used to set the priorities of the work of individual agencies.

DEPARTMENT DATA PLANNING AND ANALYSIS WORKING GROUP

The Data Planning and Analysis Working Group chaired by ASPE analyzes departmental data requirements and develops plans minimizing barriers to full utilization of such data. The Group identifies needs for data within HHS, evaluates the capacity of current systems to meet these needs and prepares recommendations for ensuring effective and efficient performance of HHS data systems.

LONG-TERM CARE MICROSIMULATION MODEL

During 1991 ASPE continue to use extensively the Long-Term Care Financing Model developed by ICF, Inc. and the Brookings Institute. The model simulates the utilization and financing of nursing home and home care services by a nationally representative sample of elderly persons for the period 1986 to 2020. It gives the Department the capacity to simulate the effects of various financing and organizational reform options on future public and private expenditures for nursing home and home care services. During 1991, ASPE continued work on making the model available to the general research community.

2. RESEARCH AND DEMONSTRATION PROJECTS

INSTITUTE FOR RESEARCH ON POVERTY, UNIVERSITY OF WISCONSIN

Robert M. Hauser, Principal Investigator.

A research agenda of diverse but interrelated 2-year studies concerned with the relationship between poverty and family structure, education and social welfare, child support and paternity, labor force behavior, and welfare dependence. In the

1991-93 biennium there are no projects dealing exclusively with the elderly. However, the Institute does do a number of activities and publishes a number of materials on poverty which include the elderly as an important subgroup.

Funding: Fiscal years 1991-93—\$3,000,000

End Date: June 1993

PANEL STUDY OF INCOME DYNAMICS

University of Michigan, Institute for Social Research, James N. Morgan, Greg J. Duncan, and Martha S. Hill, Principal Investigators.

Through an interagency consortium coordinated by the National Science Foundation (NSF contributes approximately \$1.5 million per year), ASPE assists in the funding of the Panel Study of Income Dynamics (PSID). This is an ongoing nationally representative longitudinal survey that began in 1968 under the auspices of the Office of Economic Opportunity. The PSID has gathered information on family composition, attitudes, employment, sources of income, housing, mobility, and a host of other subjects every year since then on a sample of approximately 5,000 families and has followed all original sample members that have left home. The current sample size is over 7,000 families. The data files have been disseminated widely and are used by hundreds of researchers both within this country and in numerous foreign countries to get an accurate picture of changes in the well-being of different demographic groups including the elderly.

Funding: ASPE (and HHS precursors)—FY67 through FY79—\$10,559,498; FY80—\$698,952; FY81—\$600,000; FY82—\$200,000; FY93—\$250,999; FY84—\$550,000; FY85—\$300,000; FY86—\$225,000; FY87—\$250,000; FY88—\$250,000; FY89—\$250,000; FY90—\$300,000; FY91—

SURVEY OF CONSUMER FINANCES

University of Michigan, Survey Research Center Richard Curtin, Principal Investigator

The Survey of Consumer Finances interviewed a representative sample of U.S. families in the Spring of 1983 gathering a detailed accounting of family assets and liabilities; questioning also covered financial behavior and attitudes, work status, job history, and expected benefits from pensions and Social Security. A supplemental instrument gathered information on the pension entitlement of individuals in the sample. Detailed descriptions of pension plans are being linked to household files.

Data from the survey are expected to be widely used for investigation of the distribution of holdings of various assets and liabilities, of net worth, and of entitlement to pension and Social Security benefits. In addition, these data will support research on financial behavior of individuals and on the effect of Social Security and pensions on the holdings of other assets.

The survey was jointly sponsored by the Board of Governors of the Federal Reserve System, the Department of Health and Human Services, the Department of the Treasury, the Federal Deposit Insurance Corporation, the Federal Trade Commission, and the Department of Labor.

The Survey Research Center completed the second wave of the survey. Follow-up telephone interviews with respondents from the first survey were conducted updating basic information from the original wave and adding new areas of questioning. Data from this wave will be available Winter 1988. A third in-person wave will be conducted in 1989 to obtain another household balance sheet for those in the original sample, supplemented by an additional sample of households.

Funding: ASPE—\$1,012,096; total—\$1,711,983.

Funding by FY 1982—\$750,000; 1983—\$132,096; 1984—\$130,000; 1989—\$50,000; 1990—\$50,000; 1991—\$50,000.

RESEARCH TO IMPROVE THE ACCURACY OF LONG-TERM FORECASTS OF THE SOCIAL SECURITY AND MEDICARE TRUST FUNDS.

Unicon Research Corporation.

Finis Welch and Kevin Murphy, Principal Investigators.

The research consists of two related projects. The first will estimate historical real wage growth using household data for the Current Population Survey for the period 1964 and 1987 and forecast future growth. The goal is to decompose past wage growth into growth in the wages of workers with fixed characteristics and changes in aggregate wage levels generated by changes in the composition of hours worked. The project will also forecast the future distribution of workers across groups (distinguished by sex, race, age, education, and labor force status) which will be com-

lined with estimated relative wage patterns to forecast the composition component of future wage growth.

The second project extends the analysis to evaluate the impact of changes in the relative earnings of husbands and wives on the solvency of the Social Security system. The goal is to provide estimates of the tax contributions and benefit payments of women eligible for both primary and spouse benefits. Although preliminary work indicates that increases in earnings and labor force participation of women will contribute to the solvency of the Social Security trust fund, the magnitude depends on how the increased earnings are distributed among those already working and previous nonparticipants.

Funding: FY 1989—\$87,600.

End Date: March 1992.

PENSIONS, SAVINGS, HEALTH EXPENDITURES, LONG-TERM CARE, AND RETIREMENT

1. *"Retiree Health Insurance: A Research Proposal"*

National Bureau of Economic Research.

Principal Investigators: Alan L. Gustman and Thomas L. Steinmeier.

The researchers will use several data sets to estimate the change in the value of health insurance resulting from retirement. Using these estimates the investigators will expand their previous work on the effects of pensions and social security on retirement to include the effect of retiree health benefits on the retirement decision.

Funding FY 1990—\$89,827.

Date: September 1992.

2. *"Retiree Health Benefits and the Retirement Decisions"*

North Carolina State University.

Principal Investigators: Robert L. Clark and Alvin E. Headen, Jr.

The researchers will use data from the 1988 Employee Benefits Survey and the 1988 Current Population Survey to examine the decisions of employers to provide retiree health insurance and pensions plans. They will explore the potential trade-offs between the two fringe benefits. An economic model of why workers and firms negotiate retiree health care plans will be developed and used in the derivation and analysis of employer-sponsored retiree health insurance coverage rates for retirees and for older active workers by various worker and firm characteristics.

Funding FY 1990—\$77,429.

End Date: September 1992.

3. *"Retiree Health Benefits: An Analysis of Access and Participation"*

The Urban Institute.

Principal Investigator: Shiela Zledewski.

The researchers will use the August 1988 Current Population Survey to examine the distribution of employer-based retiree health insurance benefits (by occupation, income, health, location, family status etc.) and examine the determinants of retiree participation in employer-based plans. The project will also estimate the value of the employer-provided health benefits and examine their effect on retirement income security and Government programs.

Funding FY 1990—\$120,395.

End Date: September 1992.

POLICY ASPECTS OF INTERGENERATIONAL SUPPORT FOR ELDERLY PERSONS

Brown University.

Principal Investigator: Alden Speare, Jr.

The researchers will study the determinants of financial flows between elderly persons and children outside the household, determine the extent to which shared living helps the elderly avoid poverty, and examine how intergenerational transfers and affected by government policy. The investigators will use the Survey of Income and Program Participation and the Survey of Consumer Finances.

Funding FY 1990—\$63,426.

End Date: September 1992.

HEALTH AND RETIREMENT STUDY

University of Michigan, Survey Research Center.

Principal Investigator: Tom Justen.

The Survey of Health and Retirement is a new nationally representative longitudinal survey that will gather data on health and retirement issues from U.S. households. In addition, financial and background histories will be gathered. Data from

the survey are expected to be used for investigating how changes in the Social Security system and private pension systems have affected retirement plans. These data will support research on health care needs and costs. The survey was jointly sponsored by the Department of health and Human Services and the National Institute on Aging (NIA).

Funding: NIA—FY91—\$2,500,000; FY92—\$2,500,000; FY93—\$2,500,000.

Funding: ASPE—FY90—\$200,000; FY91—\$200,000; FY92—\$100,000.

CHARACTERISTICS OF THE ELDERLY LONG-TERM CARE POPULATION AND ITS SERVICE USE

Duke University, Center for Demographic Studies.

Ken Manton, Principal Investigator.

The project is organized into two phases. In the first year there will be an analysis of the 1982-84 National Long-Term Care Survey and the National Long-Term Care Channeling Demonstration data sets. The focus will be on functional transitions at advanced ages and the impacts of long-term care services on these transitions. In the second phase, additional national data bases like the Longitudinal Supplement on Aging will be examined to refine and extend the understanding of health and functional status changes among the impaired elderly as well as trends in service use.

Funding: FY 1987—\$56,933.

End Date: December 1992.

1988 NATIONAL LONG-TERM CARE SURVEY—ADDITIONAL ACTIVITIES

Duke University, Center for Demographic Studies.

Ken Manton, Principal Investigator.

Under a grant from the National Institute on Aging (NIA), Duke University (through the Census Bureau) is conducting the 1988 National Long-Term Care Survey. Duke will produce a data file consisting of the 1982, 1984, and 1988 surveys linked to Medicare bill records. An additional grant jointly administered by NIA and the Office of the Assistant Secretary for Planning and Evaluation will support three supplementary activities: (a) a survey of informal caregivers, (b) a follow-back survey of institutionalized persons, and (c) an analysis of the effects of supply factors on respondent use of services.

Funding: FY 1987—\$300,000.

End Date: June 1992.

ANALYSIS AND COMPARISON OF STATE BOARD AND CARE REGULATIONS AND THEIR EFFECTS ON THE QUALITY OF CARE IN BOARD AND CARE HOMES

Research Triangle Institute.

Catherine Hawes, Principal Investigator.

As the Nation's long-term care system evolves, more emphasis is being placed on home and community-based care as an alternative to institutional care. Community-based living arrangements for dependent populations (disabled elderly, mentally ill, persons with mental retardation/developmental disabilities) play a major role in the continuum of long-term care and disability-related services. Prominent among these arrangements are board and care homes.

There is a widespread perception in the Congress and elsewhere that too often board and care home residents are the victims of unsafe and unsanitary living conditions, abuse and neglect by operators, and fraud. There is also the perception that an increasing number of board and care residents are so disabled that they require a level of care greater than board and care operators are able to provide.

This project will analyze the impact of State regulations on the quality of care in board and care homes and document characteristics of board and care facilities, their owners and operators, and collect information on the health status, level of dependency, program participation and service needs of residents.

Funding: FY 1989—\$350,000; FY 1990—\$300,000; FY 1991—\$400,000.

End Date: April 1993.

POST-ACUTE CARE FOR MEDICARE PATIENTS

University of Minnesota.

Robert Kane, Principal Investigator.

The primary objective of this study is to describe the "natural history" of care received by patients with five different impairments (identified by DRG) in three post-acute care modalities. These modalities include home health care, skilled nursing care, and rehabilitation. This study will not only provide a history of what care was delivered in which settings, but will also assess and compare outcomes and costs

of care across settings and impairments. In addition, the study will determine the factors that influence hospital discharge decisionmaking. This study's findings may then be used to construct a revised payment method for post-acute care in the Medicare program.

Two sets of data will be collected. The first set will contain information from hospital discharge records and pre- and post-discharge client interviews in three U.S. cities. The second set will include a 20 percent national sample of Medicare acute care discharges to be linked with the utilization files of Medicare covered services provided in post-acute care settings. Data collection has been completed, and the analysis phase is currently underway.

Funding: FY 1987—\$500,000; FY 1988—\$727,000; FY 1989—\$695,335.

End Date: March 1992.

EVALUATION OF AN APPROACH TO MAINTAINING THE MEDICAL CURRENCY OF RURAL PHYSICIANS AND HOSPITALS

Texas Tech.

A. Bryan Spives, MD.

OBRA 1987 required the Department to explore and to test the feasibility of "requiring instructions and oversight of rural physicians . . . through use of video communications between rural hospitals and teaching hospitals" to maintain and improve the quality of delivered medical care, with special emphasis on Medicare beneficiaries." This activity is to be supported jointly by HCFA and PHS, with ASPE responsible for support of necessary evaluation activities. This project will support the evaluation component.

A two-part, 3-year effort, totalling \$350,000 in evaluation, is envisioned. The first component, internal evaluation, will be supported through partial funding of the OBRA 1987-required project(s). The second component, external evaluation, will be supported through consortium funding by PHS, HCFA, and ASPE of an independent evaluation contract.

Funding: FY 1991—\$125,000; FY 1992—\$125,000.

End Date: June 1993.

EXTENSION OF 100 PERCENT STATE LONGITUDINAL MEDICARE PART B DATA TO 1990

The Circle, Inc.

Howard West, Principal Investigator.

ASPE has collected 100 percent Part B data from six carriers representing 10 states beginning in 1983. The States include are Washington, South Carolina, North Dakota, South Dakota, Minnesota, Indiana, Pennsylvania, Washington, DC, Delaware, and parts of Maryland. The data are cleaned in a common format and can be linked to 100 percent Part A MEDPAR data to create analytical files that contain both hospital and physician reimbursement. The data can support detailed analysis of individual procedures and can support analyses of such issues as physician DRG's; the effects of bundling diagnostic procedures prior to the hospital stay into the DRG payment and others. The project adds 1988 data for all carriers to the longitudinal data series.

Funding: Fiscal Year 1990—\$75,000; Fiscal Year 1991—\$20,000.

End Date: June 1992.

ASSESSMENT OF THE EFFECTS OF REIMBURSEMENT POLICY ON THE UTILIZATION OF CLINICAL LABORATORY TESTING AND THE CONTRIBUTION OF THAT TESTING IN PATIENT CARE

Abt Associates.

Steven T. Mennemeyer, Ph. D., Principal Investigator.

This research project is designed to study the effect of reimbursement policies on the volume of clinical laboratory services delivered and on the propensity of physicians to perform testing in their own offices. In addition, this research project is intended to stimulate the development of methods for monitoring laboratory performance in terms of patient care. At present the effects of reimbursement policy on laboratory utilization and the role of these laboratory services in the quality of patient care is poorly understood. There is widespread concern generated by media coverage and anecdotal evidence that the utilization of clinical laboratory services is not meeting patient needs during a period in which laboratory technology has improved dramatically. Addressing some of these concerns, Congress passed the "Clinical Laboratory Improvement Amendments of 1988" (CLIA-88). Although financial issues such as physician ownership of labs and direct payment were much debated, Congress did not act on these financial matters in the final bill. An assessment of data concerning the utilization of laboratory services is necessary for policymakers to

identify strategies that best promote advances in laboratory services in order to enhance patient care and maximize the effectiveness of health care expenditures.

Funding: Fiscal year: 1989—\$510,000.

End Date: January 1992.

ANALYSIS OF MULTIPLE SURGICAL BILLS ON THE DAY OF SURGERY

Center for Health Economics Research.

Janet Mitchell, Principal Investigator.

Medicare statistical files (BMAD) data for 1985-88 will be examined to identify patients who have received bills for more than one surgery on the same day for 15 or more high Medicare outlay surgical procedures. The contractor will first eliminate duplicate claims. The remaining claims will be sorted into three types with the aid of a medical consultant: (1) claims by the same surgeon for procedures made through the same incisions the principal procedure which are properly paid but at a reduced rate (50 percent); (2) claims by the same surgeon for related procedures to the principal procedure which under the carrier's global fee policy should not have been billed separately (e.g., billing both for a hysterectomy and sewing up the wound); claims by a different surgeon for a related procedure which could have been billed as an assistant-at-surgery claim; and (4) a second procedure through a separate incision. Estimates will be made based on this topology, and with the aid of medical advice as to when billing pattern appear inappropriate of Medicare overpayments for both potential overbillings or apparent "unbundling" from surgical global fees.

Funding: Fiscal year 1990—\$90,000.

End Date: June 1992.

ASSESSMENT OF ACCESS TO CARE IN RURAL AREAS SERVED BY ISOLATED RURAL HOSPITALS

Lewin/ICF.

Kathy Jones, Project Director.

This study analyzes the number and character of communities served by isolated rural hospitals, their current patterns of care, and the financial circumstances of the hospitals that serve them. Medicare discharge and cost report data from 1984 and 1988 are used to assess patterns of care and the financial status of isolated rural hospitals. The study will examine the extent to which patients received services at the local hospital compared to more distant facilities during 1984 and 1988.

Funding: Fiscal Year 1990—\$120,000.

End Date: Completed.

PUBLIC HEALTH SERVICE-CENTERS FOR DISEASE CONTROL

NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

The combined Health Information Database (CHID)—a Public Health Service information resource—contains health information that pertains to aging. The database includes disease prevention, health promotion, and health education information on eye diseases and disorders, Alzheimer's disease, arthritis and musculoskeletal diseases, diabetes mellitus, cholesterol, high blood pressure, digestive diseases, kidney and urologic diseases, injury prevention, exercise, weight management, and stress management. Because of the nature of the subject areas, CHID is a valuable resource for health providers working with the elderly. CHID can be accessed through most library and information services. Persons who wish to access the database directly can obtain a password from MAXWELL Online, BRS Division, Latham, NY, 1-800-345-4BRS.

In 1990, the Aging Branch was established to: (1) conduct epidemiologic research, investigations, and surveillance of selected chronic diseases and conditions; (2) develop and evaluate prevention strategies and demonstration projects; and (3) provide consultation and technical assistance to States and other agencies. Research and programmatic efforts are focused on musculoskeletal diseases (osteoarthritis, osteoporosis), chronic neurological diseases (Alzheimer's disease, Parkinson's disease), urinary incontinence, developing measures of health status and quality of life and promoting/supporting State efforts in these areas.

Musculoskeletal diseases are the most prevalent chronic diseases, affecting approximately 37 million persons in the United States. Data indicate that 40 percent of persons 65 years and older have symptomatic musculoskeletal diseases and 60 percent have clinical evidence of disease. The Aging Branch has three studies underway relating to osteoarthritis (OA). One of these is a review of the status of pre-

vention interventions for arthritis disability. The Aging Branch has four projects underway relating to osteoporosis.

Chronic neurological diseases, conditions common among the elderly, rank high in measures of morbidity, disability, family stress, and economic burden. For example, the costs due to dementias alone were estimated at \$24-48 billion in 1985, and will increase as the population ages. However, the epidemiology of these conditions is poorly understood. The Aging Branch is conducting a number of studies to better understand the epidemiology of Alzheimer's disease and Parkinson's disease.

Urinary incontinence (UI), the involuntary loss of urine so severe as to have social or hygienic consequences, affects 15-30 percent of community-dwelling older people and at least half of all nursing home residents. UI costs are conservatively estimated at 10.3 billion annually. UI goes largely untreated in millions of people, although a third of cases can be cured and another third helped significantly. The Centers for Disease Control (CDC) has determined incidence, prevalence, and remission rates for different types of UI in those 65 and older using the NHANES Epidemiologic Follow-up Study.

The CDC-funded center for Health Promotion in Older Adults (CHPOA) at the School of Public Health, University of Washington, is focusing on the health of older Americans and has as its theme "Keeping Healthy Older People Healthy." The Group Health Cooperative Demonstration Project is evaluating a nurse, educator health assessment followed by up to six intervention activities for those at risk. The Case-Control Analysis of Hip Fractures study showed cognitive dysfunction to be a major risk factor for hip fractures, along with poor tandem gait, poor balance, and impaired recovery after a displacement of balance; an intervention study of the effects of proper footwear is currently underway. The Movement Intervention Trial (MOVE-IT) is comparing the effect on gait and balance of three exercise interventions in those with mild to moderate movement impairments. A final project surveys the health care needs of older adults in Seattle Housing Authority public housing; these data will help allocate County Health Department resources. The core funding provided by CDC has helped support other studies by CHPOA staff on physical frailty, osteoporosis, and self-efficacy (the concept that one can successfully execute the behavior required to produce a desired outcome).

CDC provides technical and financial assistance to State health agencies for a wide variety of chronic disease prevention and control program activities. One of these programs targets the elderly in Flathead County, MT. The Successful Aging Program enables senior citizens to participate in planning risk factor screening and educational activities. The program has implemented interventions that target nutrition, exercise, weight control, and stress reduction. As a result of the positive results from these activities, the program is being disseminated throughout the State.

The PATCH (Planning Approach to Community Health) program has been instrumental in facilitating the initiation of interventions for older Americans in several communities. For example, the Sarasota (Florida) PATCH program has a Geriatric Committee which addresses problems facing Sarasota's senior population. The Committee has published "Help Lines", a Wallet or purse-sized phone directory of important resources for senior citizens.

Diabetes is a major contributor to morbidity and mortality among persons 65 and older. An estimated 2,898,000, or 10 percent, of all Americans 65 years of age and older have diagnosed diabetes, compared with about 2 percent of all Americans below age 65. Each year, about 290,000 new cases of diabetes are identified among those who are 65 and older. In 1987, diabetes contributed to over 119,000 deaths and an estimated 1,507,000 hospitalizations among Americans 65 and older. About \$5.2 billion in direct medical costs can be attributed annually in the United States to diabetes among persons 65 and older.

During 1991, CDC's efforts have focused on the prevention of eye disease and cardiovascular disease associated with diabetes. All diabetes control programs funded through cooperative agreements with 27 state and territorial health departments currently address visual impairment associated with diabetes, and at least one of the following complications: adverse outcomes of pregnancy, lower extremity disease, and cardiovascular disorders associated with diabetes. In 1987, among Americans with diabetes age 65 and older, there were 38,000 hospital discharges for non-traumatic amputations, and 2,720 individuals who began treatment for end-stage renal disease. Decisions about diabetes control program directions reflect state judgments about disease burden, past program direction and interests, and existing resources within the department of health.

Breast cancer is the most commonly diagnosed cancer and the second leading cause of death from cancer among American women. Breast and cervical cancer tend to be diagnosed in advanced stages relative to advancing age. In 1991, it is pro-

jected that 44,500 women will die of breast cancer and over half of breast cancers occur in older women. Breast cancer mortality could be reduced up to 30 percent, among women over age 50, if currently recommended screening guidelines, including mammography and clinical breast examination were followed (PHS, 1991). Cervical cancer mortality rates continue to decrease from 14.8/100,000 in 1973/74 to 8.3/100,000 in 1987/88. However, in those women 50 and older, the rates are still significantly higher than those of women under the age of 50, 2 and 1.3, respectively. Recent data indicate that older women have not been receiving routine screening for cervical cancer.

Current American Cancer Society screening recommendations for breast cancer in women 50 and older include annual mammography screening, annual clinical breast examination, and monthly self breast examination. For cervical cancer screening in women 50 and older, it is recommended that after three consecutive normal Papanicolaou tests with pelvic examinations have been conducted with normal results, then screening should be done based on physician discretion.

Currently, CEC is funding eight states (California, Colorado Michigan, Minnesota, New Mexico, South Carolina, Texas, and West Virginia) through the Breast and Cervical Cancer Mortality Prevention Act of 1990. These states target older women for education and screening efforts. Along with this, marketing of new Medicare benefits which support funding for Papanicolaou smears and screening mammography will occur through various channels at Federal, State, and local levels.

NATIONAL CENTER FOR ENVIRONMENTAL HEALTH AND INJURY CONTROL

Several CDC Injury Research and Demonstration Grants funded in 1986 and 1989 have focused on injury prevention in the elderly. In 1986, CDC began funding a 3-year project at the Vanderbilt University School of Medicine to study the association between psychotropic and hypotensive drugs and the risk of fall-related fractures among Tennessee Medicare enrollees. The investigators have identified potential interventions for fall-related fractures by changing patterns of medication use. In 1989, CDC funded a study aimed at identifying therapeutic interventions for improving outcomes in elderly burn patients and a study that will provide a model for assessing medication-associated crash risk in the elderly. The results of projects funded in 1989 will be available over the next 2 to 3 years.

In August 1989, a multidisciplinary conference addressing the needs of the older driver was hosted by the National Institute on Aging, the Federal Highway Administration, the National Highway Traffic Safety Administration, and CDC. The conference brought together 170 specialists in such diverse areas as ophthalmology, epidemiology, gerontology, pharmacology, human factor, and highway vehicle safety and design, to present and review the latest research findings in functional areas related to driving abilities and to identify researchable issues that apply specifically to the needs of the older driver. CDC helped to organize and develop documents that summarize the proceedings and recommendations from the conference.

An intramural study has found that nearly 55 percent of falls in persons 65 years of age and older occur in and around the home, with the rate of fall injuries increasing exponentially with age. Although females have a higher incidence of fall-related fractures, males are twice as likely to die as the result of a fall. Half the falls occurring in the home that required hospitalization resulted in ultimate discharge to a nursing home.

This research identified (a) elderly people at increased risk for being injured in a fall, and (b) interventions capable of minimizing risk without compromising functional independence. Based on some of the findings, an intervention pilot study was conducted by the Dade County Public Health Unit and CDC in conjunction with the Geriatric Assessment and Planning Program at South Shore Hospital and Medical Center in South Miami Beach, FL, in 1989. This pilot study targeted elderly persons who had recently been discharged from an acute care hospital and a second group referred by community-based providers. Successful interventions were identified and funds are presently being sought for implementation of a full-scale program.

Other collaboration has been initiated with the Center for Chronic Disease Prevention and Health Promotion to determine the impact of glycemia control on motor vehicle-associated injury in persons with insulin-dependent diabetes.

An intramural study analyzed mortality data on suicides among U.S. residents over age 65 for the period 1980 through 1986. Suicide rates during this period increased for persons over 65. Elderly, white males have the highest race and sex-specific suicide rates and experienced an increase of 23 percent, but the most dramatic increase was the 42 percent increase in the suicide rate for older black males. Divorced males over age 65 have the highest marital status-specific suicide rates.

Other specific projects funded by CDC include:

An Injury Prevention and Control Program in Baltimore County is focusing on the prevention of falls in the elderly.

A New York City program will address pedestrian injuries among the elderly in a collaborative effort with the Department of Transportation's Safety Unit and the Department of Aging.

In New York State, as an intervention strategy for local health units, a program has been funded to develop prevention packets addressing, among other issues, home safety for the elderly. Packets will serve as a management tool as well as a health promotional resource. New York State currently is conducting an intervention project on falls in the elderly.

In North Carolina, a program will support a Driver Medical Evaluation Program to keep medically impaired persons from driving. A high percentage of this population will be people over 65 years of age.

Other collaborative projects have been initiated with both the Philadelphia Health Department and the Indian Health Service to target injuries among inner-city Blacks and Native Americans. The special needs and risks of the elderly among these high-risk populations are being addressed by these programs.

NATIONAL CENTER FOR HEALTH STATISTICS

INTRODUCTION

The 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, life style, the onset and diagnosis of illness and disability, and the use of health care.

The Center maintains over a dozen surveys that collect health information through personal interviews; physical examination and laboratory testing; review of hospital, nursing home, and physician records; and other means. These data systems, and the analysis and reports that follow, 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.

Since most of the data systems maintained by NCHS encompass all age groups in the population, 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. 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 currently examine the use of hospitals, nursing homes, and physicians' offices and are being expanded to cover hospital emergency rooms, surgi-centers, home health care and hospice.

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.

A FOCAL POINT FOR DATA ON AGING

In 1989, NCHS established a focal point for data on aging by creating a position of Coordinator of Data on Aging. This focal point cuts across the Center's data systems to coordinate:

The collection, analysis and dissemination of health data on older Americans; International research in data on aging; and

—Measurement research in aging in such areas as development of a uniform data set for long-term care and assessment of disability.

The Coordinator provides information to the general public about NCHS activities and data on aging Americans.

PROPOSED SURVEY OF THE DYNAMICS OF AGING

In response to the growing interest in longitudinal data, the NCHS has developed a proposal for a Survey of the Dynamics of Aging (SODA). SODA's intent is to produce longitudinal data on older Americans to analyze health, economic well-being and critical life events in terms of their dynamic interrelationships. SODA focuses on aging successfully and on cognitive functioning. SODA gives special attention to tertiary health promotion issues, that is, issues about the prevention of dis-

ability from existing chronic conditions. This is of importance for elderly persons because they often have multiple chronic conditions. Issues concerning the basic content of interviews and of mini-physical examinations vis-a-vis policy and epidemiologic concerns were addressed in 1991. Specific recommendations for content will be developed by expert consultants in 1992.

INTERNATIONAL COLLABORATIVE EFFORT ON MEASURING THE HEALTH AND HEALTH CARE OF THE AGING

NCHS launched the International Collaborative Effort on Measuring the Health and Health Care of the Aging (abbreviated as the ICE on Aging) in 1988. The purpose of the ICE on Aging is to join with international experts in conducting research to improve the measurement of health and health care of the aging. Research results will be applied to the Center's programs to strengthen the collection, analyses, and dissemination of data on older persons. Results also will be disseminated widely to encourage their international application. The international emphasis of the research permits the exchange of perspectives, approaches, and insights among nations facing similar situations and challenges. The first International Symposium on Data on Aging was held in late 1988 to develop proposals for research in selected areas. Proceedings from the 1988 Symposium were published in 1991 in the Center's *Vital and Health Statistics Series*. The following research projects began in 1989:

- Comparative Analysis of Health Statistics for Selected Diseases Common in Older Persons—Hip Fracture: USA and Hong Kong;
- Measuring Outcomes of Nursing Home Care: USA, Australia, Canada, The Netherlands, Norway;
- The Measurement of Vitality in Older persons: USA, Italy and Israel;
- Health Promotion and Disease Prevention Among the Aged: USA and the Netherlands; and
- Functional Disability: USA, Canada, and Hungary

A second International Symposium presenting interim results of these research projects was held in 1991. Proceedings should be available in 1992. A third and final international symposium is planned for 1994-95 to present final research results.

NCHS has issued several *Information Updates for the ICE on Aging*. They described each research project in depth and detail progress. To be placed on the mailing list for past and future Information Updates, contact the NCHS Coordinator of Data on Aging.

FEDERAL INTERAGENCY FORUM ON AGING-RELATED STATISTICS

The NCHS, in conjunction with the National Institute on Aging and the Bureau on the Census, co-chairs the Federal Interagency Forum on Aging-Related Statistics. The Forum encourages communication and cooperation among Federal agencies in the collection, analysis, and dissemination of data on the older population. The Forum consists of over 20 Federal agencies that produce or analyze data on the aging population.

Recently, the Forum has prepared the following reports. Copies are available from the NCHS Coordinator of Data and Aging:

Measuring the Activities of Daily Living: Comparison Across National Surveys by Wiener, Hanley, Clark, and Van Nostrand in *Journal of Gerontology*, Vol. 45, No. 6;

Survey Assessment of Cognitive Impairment and Its Impact on Disability: Recommendations for Research; and

Directory of Federal Contacts About Older Americans in Rural Areas.

Forum activities for 1992 include:

Publication of a comprehensive statistical report and a chart-book on the health of older Americans;

Presentation of an informal briefing on older Americans in rural areas to Members of Congress and their staff. This is being conducted under the auspices of the Senate Special Committee on Aging; and

Release of a report on data about minority aging.

VITAL STATISTICS ON AGING

Mortality statistics from the national vital statistics system continue to play an important role in describing and monitoring the health of the elderly population. The data include measures of life expectancy, causes of death, and age-specific trends in death rates. The basis of the data is information from death certificates,

completed by physicians and funeral directors, used in combination with population information produced by the U.S. Bureau of the Census.

At NCHS two efforts are currently underway to both assess and improve mortality data for the elderly. NCHS is looking into the possibility of increasing the level of age detail shown in tabulations of mortality for the elderly, focussing on the age group 85 years and over, which is often treated in tabulations as an aggregated category. As life expectancy has increased, the need for detail mortality data for the "extreme aged" has increased accordingly. Current efforts involve assessing both the availability and quality of mortality and population data for more detailed age groups among the elderly.

Also under study is the process by which medical information on the death certificate is collected, including issues related to the format of the cause-of-death section. The format presently in use, prescribed by the World Health Organization, requests that the certifying physician report single causal chain of medical events that led to death, initiated by an "underlying" cause of death. The single sequence concept presents difficulties in certification for some elderly deaths which may reflect the consequences of several concurrent disease processes. These and other issues related to certification are now under study.

DATA BASE NEWS IN AGING

NATIONAL HEALTH INTERVIEW SURVEY (NHIS): SPECIAL TOPICS

The NHIS continues to collect data on a wide range of special health topics for the civilian, noninstitutionalized population, including the aging population. The special health topics for 1991 were:

Health promotion and disease prevention items related to the National Health Objectives for the Year 2000 (one sample adult per family);

Illicit drug use (same sample adult);

AIDS knowledge and attitudes (same sample adult);

Income and program participation (all family members);

Hearing impairment (all family members).

The special health topics for 1992 are cancer epidemiology and cancer screening. For 1993 and 1994 the special topic is disability.

Data collection for an NHIS data year begins in January of that year and ends in December. Public-use data tapes are usually available about one year after the end of the data collection.

NATIONAL HEALTH PROVIDER INVENTORY (NHPI)

NCHS conducted the NHPI, formerly called the National Master Facility Inventory, in the spring of 1991. This mail survey includes the following categories of health care providers: nursing and related care homes, licensed residential care facilities, facilities for the mentally retarded and mentally ill, home health agencies, and hospices. Data from the 1991 NHPI will be used to provide national statistics on the number, type, and geographic distribution of these health providers and to serve as sampling frames for future surveys in the Long-Term Care Component of the National Health Care Survey. The 1991 NHPI public-use tapes will be released in 1992.

NATIONAL MORTALITY FOLLOWBACK SURVEY: 1986 AND 1993

Data collection has been completed on the National Mortality Followback Survey, the first such survey in 18 years. Already, 43 papers and publications have used the data. The followback survey broadens the information available on the characteristics of mortality among the population of the United States from the routine vital statistics systems by making inquiry of the next of kin of a sample of decedents. Because two-thirds of all deaths in the Nation in a year occur at age 65 or older, the 1986 survey focussed on the study of health and social care provided to older decedents in the last year of life. This is a period of great concern for the individual, the family and community agencies. It is also a period of large expenditures. Agency program planning and national policy development on such issues as hospice care and home care can be enlightened by the data from the survey. A public use data tape from the next-of-kin questionnaire was released in 1988. A second tape, combining data from the next-in-kin and hospitals and other health facilities, was available in 1990. Several survey reports focused on the aging. They were about persons dying of diseases of the heart and of cerebrovascular disease. A 1993 National Mortality Survey is currently being planned.

NATIONAL NURSING HOME SURVEY

During 1985, NCHS conducted the National Nursing Home Survey (NNHS) to provide valuable information about older persons in nursing homes. The NNHS was first conducted in 1973-74 and again in 1977.

Preliminary data from the 1985 survey were published in 1987 and 1988 about nursing home characteristics, utilization, discharges, and registered nurses. A summary report, which integrated final data from the various components of the survey, was published in 1989. Also published were analytical reports on: diagnostic related groups, utilization, discharges, current residents and mental health status. Public-use computer tapes are available through the National Technical Information Service.

NATIONAL NURSING HOME SURVEY FOLLOWUP

The National Nursing Home Survey Followup (NNHSF) is a longitudinal study which follows the cohort of current residents and discharged residents sampled from the 1985 NNHS described above. The NNHSF builds on the data collected from the 1985 NNHS by extending the period of observation by approximately 5 years. Data collection has been completed. Wave I was conducted from August through December 1987, and Wave II was conducted in the fall of 1988. Public use data tapes for Waves I and II will be available in 1992. Wave III began in January 1990 and continued through April. The study is a collaborative project between NCHS, HHS, and the National Institute on Aging (NIA). The Followup was funded primarily by NIA and was developed and conducted by NCHS.

The NNHSF interviews were conducted using a computer-assisted telephone interview system. Questions concerning vital status, nursing home and hospital utilization since the last contact, current living arrangements, Medicare number, and source of payment were asked. Respondents included subjects, proxies, and staff of nursing homes.

The NNHSF will provide data on the flow of persons in and out of long-term care facilities and hospitals. These utilization profiles will also be examined in relation to information on the resident, the nursing home and the community.

LONGITUDINAL STUDY ON AGING

The Longitudinal Study on Aging (LSOA) has been a collaborative effort of the National Center for Health Statistics and the National Institute of Aging. The baseline information for the LSOA came from the Supplement on Aging (SOA), a supplement to the 1984 National Health Interview Survey (NHIS).

The SOA included 16,148 persons 55 years of age and over living in the community in 1984. The Supplement obtained information on housing, including barriers and ownership; support, including number and proximity of living children and recent contacts in the community; retirement, including reasons for retirement and sources of retirement income; and measures of disability, including activities of daily living, instrumental activities of daily living and ability to perform work-related activities.

The sample for the LSOA came from the 7,541 persons who were 70 years of age and older at the time of the SOA in 1984. The survey was designed to measure changes in functional status and living arrangements, including institutionalization. Reinterviews were conducted in 1986, 1988, and 1990. The recontacts were primarily by telephone using Computed Assisted Telephone Interviewing (CATI); however, when the telephone contact was not feasible, a mail questionnaire was sent to the sample person. In addition, to the three reinterviews, permission was obtained from the sample person or proxy to match their records with other records maintained by the Department of Health and Human Services.

The fourth version of the LSOA public use data tape was released in October 1991. The information for the Version 4 files was obtained from:

- 1984 NHIS, SOA, and Health Insurance Supplement to the NHIS
- 1986, 1988, and 1990 telephone interviews with mail follow-up
- 1984-1989 National Death Index (NDI) match
- 1984-1990 Medicare records match

The public use data tape includes three files—one for persons, one for Medicare hospitalizations, and one for other Medicare use. Each file includes the information obtained in the previous reinterviews. A diskette containing detailed multiple cause of death data for the LSOA sample is available. The diskette complements the Version 4 public use data tape. Future releases of the LSOA public use data tape will include information from additional matches to the NDI and Medicare files.

The LSOA Version 4 public use data tape is available from three sources: The National Technical Information Service (NTIS), The Division of Health Interview Sta-

tistics, HCHS, and the National Archives of Computerized Data on Aging. The diskette will be available from NTIS.

NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY III

The National Health and Nutrition Examination Survey (NHANES) provides valuable information available only through direct physical examinations of a probability sample of the population. The third cycle of this survey, NHANES III, went into the field in 1988. NHANES III will provide a unique data base for older persons, as a number of important methodologic changes have been made in the survey structure. There is no upper age limit (previous surveys had an age limit of 74 years), and the sample has been selected to include approximately 1,3000 persons aged 80 or older. The focus of the survey includes many of the major chronic diseases of aging which cause morbidity and mortality including cardiovascular disease, osteoarthritis, osteoporosis, pulmonary disease, dental disease, and diabetes.

In addition to the focus on nutrition, information on social, cognitive, and physical function is incorporated into the survey. Data from home examinations will be available for those unable or unwilling to come to the central examination site, the Mobile Examination Center. The major activity in 1991 was the fielding of the survey. In 1992 National Death Index and Medicare matches will be instituted as the first step in longitudinal followup. Content development and a Request for Contract will occur in 1992 on planned longitudinal followup to begin in 1995.

NHANES I EPIDEMIOLOGIC FOLLOWUP SURVEY

The first NHANES (NHANES I) was conducted in the period 1971-75. The NHANES I Epidemiologic Followup Survey, conducted by NCHS over the last several years, tracks and reinterviews the more than 14,000 persons examined as part of the NHANES I study. The main objective of the followup is to relate baseline characteristics to subsequent morbidity and mortality. While persons examined in NHANES I were all under age 75, by 1986 more than 2,000 of these individuals were over 75, providing a valuable study group to examine the aging process. Person age 55 and over at baseline were interviewed in 1986 and the entire surviving cohort was recontacted in 1987 and in 1991 to further study mortality, institutionalization, health status, and functioning. An additional wave of followup is scheduled for 1992. Public use data tapes are available for the 1982-84 and 1986 followups. A public use data tape for the 1987 recontact was released in late 1991. Future plans include monitoring the deaths in this population.

IMPROVING QUESTIONS ON FUNCTIONAL LIMITATIONS

The National Laboratory for Collaborative Research in Cognition and Survey Measurement of NCHS conducted several cognitive research projects with old (65-74), very old (75-84), and oldest (85+) respondents. The objectives were to test the adequacy and suggest improvements to existing survey questions for collecting information on functional limitations (e.g., limitations on bathing, dressing, transferring), life history events (education, employment, residence, onset of health conditions) and falls. Pending funding, a field experiment is anticipated in 1992 to test the functional limitation survey questions for the oldest respondents.

NATIONAL HEALTH CARE SURVEY (NHCS)

In response to changes during the past decade in the delivery of health care, the National Center for Health Statistics is restructuring its four surveys of health care providers. The National Ambulatory Medical Care Survey, the National Hospital Discharge Survey, the National Nursing Home Survey, and the National Master Facility Inventory are being merged and expanded, over time, into an ongoing, integrated NHCS. In part, this is being accomplished by reducing the sample sizes for health care providers covered in existing surveys and by stretching the sample over a number of years.

The primary objectives of the NHCS area: to provide national data for "alternative" sites of health care, such as hospital emergency an outpatient departments, ambulatory surgi-centers, home health agencies, and hospices; to increase the analytical uses of survey data through the use of an integrated cluster sample design; to develop the capability to conduct patient follow-up studies to examine issues related to the outcome and subsequent use of medical care; and to survey health care providers on an annual basis, thus eliminating gaps in data.

The NCHS is designed to cover the three major types of health care as well as inventory health care providers:

Hospital care

- Inpatient
- Outpatient surgery
- Outpatient department and clinics
- Emergency departments

Ambulatory Care

- Physicians' offices
- Prepaid practice, including HMO's
- Freestanding surgi-centers

Long-Term Care

- Nursing and personal care homes
- Home health agencies
- Hospices

Health Provider Inventory

- Nursing and personal-care homes
- Hospices
- Home health agencies
- Residential care homes
- Facilities for the mentally retarded
- Facilities for the mentally ill

The National Ambulatory Medical Survey and the National Hospital Discharge Survey are ongoing. Plans call for implementing surveys to cover the "alternative" sites listed above in 1992 to 1994.

NATIONAL CENTER FOR INFECTIOUS DISEASES

Infectious diseases have a disproportionate impact on older Americans. Pneumonia and influenza remains the sixth leading cause of death in the United States and septicemia has risen dramatically during the past three decades to become the 13th leading cause of death. Pneumonia and septicemia are also contributing and precipitating factors in the deaths of many Americans with other illness, especially cardiovascular diseases, cancer, and diabetes. The morbidity caused by infectious diseases is a major detriment of quality of life for millions of older Americans. By preventing and controlling these diseases, we will greatly enhance and extend their lives.

In the area of nosocomial infections, CDC continues its efforts to define risk factors for the prevention and control of institutionally acquired infections in skilled nursing facilities (SNFs). Through a cooperative agreement, a project focusing on patients with infectious diseases and infection control programs in SNFs was conducted in Connecticut. The goal was to improve the prevention of nosocomial infections by identifying infectious diseases in skilled nursing homes, identifying associated risk factors and characterizing infection control programs in these facilities. Analysis of data from this study has been completed and two reports have been accepted for publication in the *American Journal of Infection Control*. "Infection Control Practitioners and Committees in Connecticut Skilled Nursing Facilities" and "Infection Control Practices in Connecticut's Skilled Nursing Facilities." This project demonstrated that the number of infection control practitioners increases and that practitioners devoted more time to infection control activities. Almost all SNFs had programs to prevent decubitus ulcers. However, less than one-half of SNFs reported that 90 percent or more of their patients received influenza vaccine—numerous outbreaks were reported. Influenza vaccine coverage is an area to target for improvement.

Although delivering influenza vaccine to persons at risk is a critical step in preventing morbidity and mortality from influenza, it is only part of the prevention equation. CDC's efforts to combat influenza in the elderly include: conducting immunological studies involving laboratory and clinical evaluation of inactivated and live attenuated influenza vaccines in an effort to identify improved vaccine candidates; increasing surveillance of influenza in the Peoples' Republic of China and other countries in the Pacific Basin to better monitor antigenic changes in the virus; improving methodologies for rapid viral diagnosis; and using recombinant DNA techniques to develop influenza vaccines that may protect against a wider spectrum of antigenic variants.

Pneumococcal pneumonia causes an estimated 40,000 deaths each year; 80-90 percent of these are in persons >65 years old. Prevention of pneumococcal disease in the elderly requires widespread application of effective immunization. However, the currently formulated vaccine covers only certain serotypes. CDC is working to devel-

op and promote the widespread use of an improved pneumococcal vaccine with expanded coverage and enhanced efficacy. This will substantially decrease mortality and morbidity from pneumococcal infections in the elderly. Cost-benefit analyses, which are favorable for the current vaccine, would be more heavily weighted in favor of a more effective vaccine.

Group B streptococcus (GBS) is a major cause of invasive bacterial disease in elderly persons in the United States. To document the magnitude of GBS disease in the elderly and develop preventive measures, including an evaluation of utility and cost effectiveness of vaccines to reduce incidence, the CDC will: establish population-based surveillance for GBS disease; perform case control studies to identify risk factors for disease in the elderly; evaluate vaccine immunogenicity and efficacy in elderly populations at high risk; and measure the impact of preventive measures through surveillance. The project will result in a prevention program for GBS disease including evaluation of a role for vaccination based on the risk factor study, incidence data, and efficacy trial results.

Recent studies have suggested that noninfluenza viruses such as respiratory syncytial virus and the parainfluenza viruses may be responsible for as much as 20% of serious lower respiratory tract infections in the elderly. These infections can cause outbreaks that may be controlled by infection control measures and be treated with antiviral drugs. Consequently, it is important to define the role of these viruses and risk factors for these infections among the elderly population. CDC plans to set up collaborative studies with state public health departments to do surveillance on outbreaks of respiratory illness in nursing homes and assess transmission patterns and efficacy of prevention programs.

Studies using information from national databases show that of all age groups, the elderly (>70 years) have the greatest number of hospitalizations and deaths associated with diarrhea in the United States. To evaluate more precisely the public health significance and potential prevention and treatment modalities of diarrhea in the elderly, the CDC plans to initiate prospective multi-center studies in high risk groups such as the elderly in nursing homes and hospitals as well as prospective studies on incidence and impact of diarrhea in elderly outpatients.

The causes of the steady increase in deaths due to septicemia have not been fully explained by existing studies. CDC plans to examine in depth the issues related to this rise in septicemia mortality and assess the relative contributions of various potential risk factors, including changes in population, impact of newer medical therapies, and other currently undefined factors. Studies of the cost-benefits of preventing these infections will also be done.

NATIONAL CENTER FOR PREVENTION SERVICES

IMMUNIZATION

CDC is continuing its efforts to increase the awareness of adults to be immunized against the vaccine-preventable diseases of influenza, pneumococcal disease, hepatitis B, measles, mumps, rubella, tetanus, and diphtheria. As a liaison with outside organizations, such as the Administration on Aging, the American College of Physicians, and the American Hospital Association that promote adult immunization activities, CDC provides speakers for conferences and technical review of documents. CDC responds to public inquiries and has revised a booklet for the lay public, *Immunization of Adults—A Call to Action*, which promotes immunization of adults in the community. CDC is also continuing assistance to State and local health systems in expanding immunization program coverage of adult populations through promotion of the Recommendations of the Immunization Practices Advisory Committee (ACIP) of Adult Immunization. These recommendations were recently updated for reissuance in November 1991.

CDC continues to include adult immunization issues in its annual National Immunization Conferences. In the 23rd and 24th Conferences held in San Diego, CA, in June, 1989, and in Orlando, FL, in May, 1990, respectively, at least eight oral presentations addressed various adult immunization issues. In the 25th Conference held in Washington, D.C. in June 1991, there were two oral and one poster presentation concerning adult immunization. The proceedings from the 23rd and 24th Conferences have been published; those from the 25th Conference will be published and distributed in late 1991.

A 3-year cooperative agreement was completed with a health maintenance organization (HMO) trade organization to measure vaccine use and develop procedures to increase acceptance of adult vaccines by HMO subscribers. The major accomplishments under this agreement include: (1) a survey of HMO policies regarding availability of adult immunization to subscribers; (2) an assessment of vaccine coverage

and vaccine-preventable disease morbidity and mortality in five HMOs; (3) aggressive intervention promotion of influenza vaccine in the fall of 1989 by the five HMOs; (4) assessment of morbidity and mortality among vaccinated and unvaccinated subscribers after the intervention, as well as the cost-effectiveness of the intervention (these data are still being compiled); and (5) a final report to the HMO industry about the agreement, to be published in 1992.

CDC continues to participate in the National Coalition for Adult Immunization (NCAI), a network of 54 private, professional, and volunteer organizations, and public health agencies with the common goal of improving the immunization status of adults. Each year during the last week of October, the NCAI promotes National Adult Immunization Awareness Week to emphasize the importance of vaccinating all adults. To unify the diverse interests of the member organizations and offer a foundation of common goals, the NCAI has developed and adopted the *Standards for Adult Immunization Practice*. The standards outline basic strategies that, if fully implemented, would improve delivery of vaccines to adults and help achieve the Year 2000 National Health Objectives. The objectives of the NCAI are accomplished by three working Action Groups—Influenza/Pneumonia, Measles-Mumps-Rubella, and Hepatitis B—that conduct disease-specific informational and educational activities for health care providers and the public. To combat influenza and pneumococcal disease as leading causes of morbidity and mortality for persons over age 64 and to increase the number of health care providers who offer these immunizations, the Influenza/Pneumonia Action Group has formed eight State and local-based coalitions across the United States. Each coalition is responsive to the needs of its community, developing a variety of implementation approaches including immunization policy development and local promotional campaigns.

CDC and the Health Care Financing Administration (HCFA) are jointly conducting a demonstration project to determine the cost-effectiveness for Medicare to cover the use of influenza vaccine. This project involves the administration of influenza vaccine to Medicare Part B recipients in 10 sites for cost-effectiveness studies, and in an additional 10 statewide sites to assess three levels of vaccine promotion and the effectiveness of vaccine delivery by simply making it a covered benefit under Medicare Part B. Vaccine doses delivered in the cost-effectiveness sites exceeded 786,000 in 1990–91, up from approximately 480,000 in 1989–90, and reached 41 percent of the Medicare Part B population in those sites. Over 1,300,000 doses of vaccine were distributed in the 10 statewide sites in 1990–91, reaching 28 percent of the Medicare Part B population. The demonstration will be completed in September 1992 and a final report will be submitted to Congress in April 1993. If the project successfully demonstrates cost-effectiveness, influenza vaccine coverage will become a routine covered expense under the Medicare Part B program.

CDC and HCFA are also participating in an interagency agreement, begun in 1989, to study the effectiveness of pneumococcal vaccine in preventing morbidity and mortality among the Medicare Part B beneficiaries in Hawaii. Medicare records will be used to: (1) Evaluate the clinical effectiveness of pneumococcal vaccination in preventing hospitalization and death of Medicare beneficiaries; (2) describe medical care utilization patterns of vaccinated and unvaccinated persons; (3) evaluate hospital care patterns of vaccinated and unvaccinated persons; and (4) evaluate long-term outcomes of individuals in relationship to vaccination status. The interagency agreement will continue into 1993.

TUBERCULOSIS

Tuberculosis (TB) among the elderly is an important problem in that TB case rates among the elderly are higher than in any other age group. During 1990, 6,115 TB cases were reported among persons age 65 and older—the case rate for persons of all ages was 10.3 per 100,000 population while the rate for persons age 65 and older was 19.6.

Elderly residents of nursing homes are at even higher risk for developing TB than elderly persons living in the community. According to a CDC-sponsored survey of 15,379 reported TB cases in 29 States, the incidence of TB among elderly nursing home residents was 39.2 per 100,000 person-years while the incidence of TB among elderly persons living in the community was 21.5 per 100,000 person-years. Investigators have also documented transmission of tuberculosis infection to residents and staff in nursing homes during TB outbreaks.

During 1990, the CDC and the HHS Advisory Council for Elimination of Tuberculosis published recommendations for controlling TB among nursing home residents and employees. The recommendations call for TB screening of nursing home residents upon admission and employees at entry, annual rescreening for employees, attention to timely case-finding among symptomatic elderly persons, and the use of

approximate precautions to prevent the spread of TB in facilities providing residential care for elderly persons.

ORAL HEALTH AND DENTAL DISEASE PREVENTION

CDC and the National Institute of Dental Research, NIH, have developed a plan to achieve functional and healthy oral conditions for all Americans. The U.S. Public Health Service (PHS), through its Oral Health Coordinating Committee, is taking steps to implement Oral Health 2000, an adult oral health initiative. This initiative, viewed as a decade-long commitment, represents the collective effort of PHS agencies to accelerate improvement in oral health for adult Americans—particularly those at increased risk of oral diseases including older adults. The private and voluntary sector will also be involved to facilitate comprehensive approaches to reduce the occurrence and severity of oral diseases; prevent the unnecessary loss of teeth in the U.S. population; and alleviate physical, cultural, racial/ethnic, social, educational, economic, health care delivery, and environmental barriers that prevent adults from achieving good oral health.

Persons are at higher risk for oral cavity and pharyngeal cancer as their age increases. Approximately 95 percent of oral cavity and pharyngeal cancer occurs in persons aged 40 and over, with the average age at diagnosis being 60 years. Individuals aged 65 and over experience poorer survival rates from these cancers. The Dental Prevention Activity, NCPDS, has developed liaisons with Federal and State agencies to: (1) assess the magnitude of the disease burden from cancers of the oral cavity and pharynx; (2) determine the extent of programs currently in place that address the problem; and (3) stimulate the development of comprehensive public health strategies to reduce incidence and mortality rates in the United States. CDC and NIH have developed a monograph on oral cavity and pharyngeal cancers to provide the public health, research, education, and health care provider communities with detailed information on the incidence, mortality, and 5-year relative survival rates for oral and pharyngeal cancer in the United States. This publication was distributed in November 1991.

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

The Office of Disease Prevention and Health Promotion (ODPHP) was established by Public Law 94-317, the National Consumer Health Information and Health Promotion Act of 1976, and functions under the provisions of Title XVII of the Public Health Service Act, as amended. Located within the Office of the Assistant Secretary for Health, at the U.S. Department of Health and Human Services (HHS), the mission of ODPHP is to help promote and prevent disease among Americans. The Office undertakes this mandate by developing prevention policy; coordinating and facilitating the prevention activities of the eight agencies of the Public Health Service (PHS); and helping to stimulate and foster the involvement of non-Federal groups in disease prevention and health promotion activities.

People who reach the age of 65 can now expect to live into their eighties. However, it is likely that not all those years will be active and independent ones. Thus, improving the functional independence, not just the length, of later life is an important element in promoting the health of this age group.

One measure of health that considers quality as well as length of life is the years of healthy life. While people aged 65 and older have 16.4 years of life remaining on average, they have about 12 years of healthy life remaining. Another indicator of quality of life is an individual's ability to perform activities required for daily living, such as bathing, dressing, and eating. Difficulty in performing these necessary tasks leads to the need for assistance and often limits opportunity for remaining independent in the community. People aged 85 and older constitute a substantial share of all people who are not independent in physical functioning.

While many people think of health problems in old age as inevitable, a substantial number are either preventable or can be controlled. The major causes of death among people aged 65 and older are heart disease, cancer, stroke, chronic obstructive pulmonary disease, pneumonia, and influenza. Chronic problems, such as arthritis, osteoporosis, incontinence, visual and hearing impairments, and dementia, are of equal concern because of their significant impact on daily living. To accommodate the changing needs of an increasingly older society, we must prevent the ill from being disabled and help people with disabilities preserve function and prevent further disability.

A growing body of evidence shows that changing certain health behaviors, even in old age, can benefit health and quality of life. Cigarette smoking is one of these habits. Studies have shown that when older smokers quit, they increase their life

expectancy, reduce their risk of heart disease, and improve respiratory functions and circulation. Good nutrition is also important in the promotion and maintenance of health for older adults. Diet can play an important role in mitigating existing health problems with older people. Reducing sodium intake and losing weight, for example, can help keep blood pressure under control, and there is a growing evidence that nutrition counseling and food programs can reduce the risk of disease among older adults.

Another key ingredient to healthy aging is physical activity. Often physiological decline associated with aging may actually be the result of inactivity. Increased levels of physical activity are associated with a reduced incidence of coronary heart disease, hypertension, noninsulin-dependent diabetes mellitus, colon cancer, and depression and anxiety which are diseases prominent in older adult populations. Moreover, increased physical activity increases bone mineral content, reduces the risk for osteoporotic fractures, helps maintain appropriate body weight, and increase longevity. It may also be that increased physical activity levels can improve balance, coordination, and strength, factors that may reduce the likelihood of falls in the older adults.

People over age 65 also need regular primary health care services to help them maintain their health and prevent disabling and life-threatening diseases and conditions. Clinical preventive services include the control of high blood pressure, screening for cancers, immunization against pneumonia and influenza, counseling to promote healthy behaviors, and therapies to help manage chronic conditions such as arthritis, osteoporosis, and incontinence. Especially important among these clinical services are those to detect breast cancer: screening mammography and clinical breast examination. These interventions are estimated to reduce mortality from breast cancer in women over age 50 by about 30 percent. In addition, Pap tests to detect cervical cancer are important for older as well as for younger women. Careful reviews of medication use and patient counseling by health professionals are other important services for this population in order to reduce the risk of adverse reactions and other problems associated with the use and misuse of medications.

HEALTHY PEOPLE 2000: NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES FOR THE YEAR 2000

ODPHP was responsible for the development of *Healthy People 2000*, released by Secretary Louis W. Sullivan in September 1990. This report, the product of an unprecedented cooperative effort among government, voluntary and professional organizations, business, and individual citizens, has launched a national initiative to improve the health of Americans significantly in 10 years through a coordinated and comprehensive emphasis on prevention. Forming the cornerstone of this effort is a set of national health promotion and disease prevention objectives for the year 2000.

Healthy People 2000 sets broad public health goals for a decade, as did the first *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* in 1979. The three principal goals for the 1990s are to—

- Increase the span of healthy life for Americans.
- Reduce health disparities among Americans.
- Achieve access to preventive services for all Americans.

To help meet these goals, 300 specific objectives have been identified in 22 separate priority areas. Quantifiable targets have been set for improvements in health status, risk reduction, and service delivery to consolidate the gains made in the 1980s and extend the benefits of prevention to those groups who experience higher rates of morbidity, disability, and mortality than the general population. Organized under the broad approaches of health promotion, health protection, and preventive services, the national objectives chart a 10-year course for individual, collective, and environmental change.

The year 2000 health objectives succeed the 1990 health objectives that were set in 1980, following publication of *Healthy People*. Several themes distinguish the two efforts, reflecting the progress and experience of 10 years, as well as the expanded science base. A greater emphasis is placed on health outcomes other than premature mortality, reflecting a new appreciation for the prevention of morbidity and disability that can impair functional capacity. Furthermore, while significant improvements have been made in the Nation's health profile over the past decade, gains have not been universal. Many of the new objectives aim specifically at improving the health status of certain groups of people who bear a disproportionate burden of suffering compared to the general population. This emphasis will be especially critical in the 1990s since many of these groups will also be experiencing a faster rate of growth than the population as a whole.

To help address those objectives in *Healthy People 2000* which focus specifically on or are strongly related to the health of older adults, ODPHP has awarded a cooperative agreement with the American Association of Retired Persons (AARP) to assist in the development of a Healthy Older Adults 2000 campaign. AARP's initiative encourages health and aging organizations to extend health promotion, health protection, and preventive services to their constituents. Currently, more than 900 national, State, and local organizations are part of the Healthy Older Adults Action Alliance, a network of groups interested in programming to achieve the national objectives. A second part of the campaign has been the development of a Recognition Program for Exemplary Contributions to Healthy Aging, a national awards program to identify outstanding health promotion programs that currently address one or more of the objectives for older adults.

FOOD AND DRUG ADMINISTRATION

As the percentage of elderly 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. FDA has been focusing on several areas for the elderly that fall under its responsibility in the regulation of foods, drugs, and medical devices. Efforts in education, labeling, drug testing, drug utilization, and adverse reactions have been of primary interest. Close relationships have been established with both the National Institute on Aging and the Administration on Aging of the Department of Health and Human Services to further strengthen programs that will assist the elderly in their medical care. Some of the major initiatives that are underway are described below.

PATIENT EDUCATION

To further the goals established by the joint Public Health Service/Administration on Aging Committee on Health Promotion for the Elderly, during the last 8 years FDA has coordinated the development and implementation of significant patient education programs with the National Council on Patient Information and Education (NCPIE) and many private sector organizations. NCPIE is a nongovernmental group consisting of medical pharmacy, consumer, and pharmaceutical organizations whose goal is to stimulate patient education and program development. Special emphasis has been placed on the elderly, who use more prescription drugs per capita than the rest of population.

The "Get the Answers" campaign is the primary program urging patients to ask their health professionals questions about their prescriptions. The major component of the campaign is a medical data wallet card that lists the five questions patients should ask when they get a prescription. These questions are:

- What is the name of the drug and what is it supposed to do?
- How and when do I take it—and for how long?
- What foods, drinks, and other medicines, or activities should I avoid while taking this drug?
- Are there any side effects, and what do I do if they occur?
- Is there any written information available about the drug?

The "Get the Answers" message has been widely disseminated to consumers through news releases, advice columns, and other media.

FDA's Center for Drug Evaluation and Research issued an FY 1989 assignment to the Field Public Affairs Specialists (PAS) to conduct Patient Education Forums to discuss the problems of prescription medication misuse and to plan the October 1989 "Talk About Prescriptions" month campaign. One of the main target audiences for these forums is organizations that work with the elderly.

In FY 1990, field Public Affairs Specialists supported the "Talk About Prescriptions" initiative not just in October but in yearround activities. The elderly in ethnic communities were targeted. Coalition building with leaders of State pharmaceutical, health, university, government, and consumer organizations was especially emphasized. A popular activity was the "Brown Bag Clinic," in which the elderly are encouraged to bring all their current medications in a brown bag to a central location where a pharmacist consults with them individually on outdated medications, drug interactions, and conflicting dosage regimens.

The Women and Medicines Campaign was initiated during "Talk about Prescriptions" month, October 1991. The purpose of the Campaign is to ensure safer and more effective use of medicines through improved communication between women and health care providers (e.g., doctors, pharmacists, dentists, nurses). The Campaign focuses on concerns related to all women, but especially special populations, such as the elderly and minorities. It is important because women use more medi-

cines than men and serve as the medicine managers for other family members. To date a brochure and planning guide have been produced by the National Council on Patient Information and Education with the support and assistance of FDA. These materials can be used in many settings, including classrooms, waiting rooms, workplace seminars, and health fairs. Other information and awareness materials will be available at a later date.

The brochure "Medicines: What Every Woman Should Know," shares information that will assist women to improve communication with health care providers. The planning guide, "Women Have Special Information Needs," shares information that will assist health care providers improve communication with women.

Concurrent with the activities aimed at patients, FDA, NCPIE and many private sector organizations are conducting a major campaign to encourage health professionals to provide drug information to their patients. Urging consumers to "Get the Answers" and health professionals to "Give the Answers" is vital to bridge the communications gap—to get both sides to talk to each other about medications.

In addition to patient education initiatives, FDA and NCPIE are continuing to evaluate the effectiveness of patient education programs and are monitoring the attitudes and behavior of consumers and health professionals about patient drug information. FDA is encouraged by the number and quality of patient education activities undertaken by the various sectors. FDA will continue to provide leadership to foster the patient education initiative.

FDA's continuing patient education initiatives include the publication of the reprint "Testing Drugs in Older People" from the November 1990 *FDA Consumer* magazine. This article discusses the physiological changes that occur in aging bodies and the need for medication adjustment.

PREMARKET TESTING GUIDELINES

FDA's efforts to ensure that premarket testing adequately considers the needs of older people also include educational activities for Institutional Review Boards (IRB) through workshops and the dissemination of information sheets on a variety of topics of interests to IRBs. An IRB governs the review and conduct of all human research at a particular institution involving products regulated by FDA. This aspect of drug testing and research is particularly important to institutional patients, a category comprised of a large number of elderly persons, to ensure adequate protection with regard to informed consent. FDA continues to work closely with the National Institutes of Health to develop and distribute information sheets to clinical investigators and members of the IRB community.

POSTMARKETING SURVEILLANCE EPIDEMIOLOGY

In the area of postmarketing surveillance and epidemiology, the Office of Epidemiology and Biostatistics has introduced a section of the annual adverse drug reaction report focusing on adverse drug reaction reports for individuals over the age of 60. Of the approximately 71,000 adverse reaction reports FDA received in 1990, over 31,000 had age and sex reported. Of these reports, 30 percent were for individuals 60 years of age or over.

In addition to annual review of ADR reports for the elderly, we have also examined drug use patterns using information obtained from IMS America Ltd. The top five ranked drugs as written by physicians for patients age 65 or over have been Lasix, Lanoxin, prednisone, digoxin, and Capoten.

GERIATRIC LABELING

From March through May 1988, FDA's Drug Labeling, Research and Education Branch (DLREB) conducted a survey of the professional labeling of some 425 selected drugs for geriatric information. The survey drugs were chosen from the data bases such as the National Disease and Therapeutic Index (NDTI) which list agents commonly used in the elderly. Half (212) of the products surveyed contained geriatric information. The drug classes with the greatest number of agents with geriatric information included the central nervous system agents (89 percent), gastrointestinal/genitourinary agents (79 percent), antiarthritic agents (77 percent), hypoglycemic drugs (75 percent), and respiratory agents (70 percent). The classes with the least amount of geriatric labeling were the glaucoma agents (26 percent) and antibiotics (31 percent). A first draft was submitted for internal review in May 1990. After allowing sufficient time for review, submission to a journal is expected.

On November 1, 1990, FDA published a proposed rule to amend its regulations pertaining to the content and format of prescription drug product labeling (55 FR 46134). The proposed rule would require a person marketing a prescription drug to

collect and disclose available information about the drug's use in the elderly (persons aged 65 years and over). "Available information" would encompass all information in the applicant's possession that is relevant to an evaluation of the appropriate geriatric use of the drug, including the results from controlled studies, other pertinent pre-marketing or post-marketing studies or experience, or literature entitled "Geriatric use" with reference, as appropriate, to more detailed discussions in other parts of the labeling, such as the "warnings" or "Dosage and Administration" sections. The proposed rule is not intended to alter the type or amount of evidence necessary to support drug approval but is intended to ensure that special information about the use of drugs in the elderly is well organized, comprehensive, and accessible.

Public comments on this proposed rule were due by December 31, 1990. FDA is currently preparing responses to public comments received and anticipates a final rule based on the proposal to publish in the Federal Register in the spring of 1992.

ACTIVITIES WITH THE AARP PHARMACY SERVICES DIVISION

Medication Information Leaflets (MILS) for Seniors

The American Association of Retired Persons (AARP) Pharmacy Services Division, in conjunction with FDA's Drug Labeling, Research and Education Branch (DLREB) publish MILS—educational leaflets about drugs written for use through the AARP prescription drug mail order program. In 1989, MILs were written for the following classes of drugs: nonsteroidal anti-inflammatory drugs, beta-blockers, beta-blocker/thiazide combination drugs, and potassium-sparing diuretics and hydrochlorothiazide combination drugs. Additionally, MILs were revised for several agents including: warafirin, belladonna alkaloids and barbiturates, isosorbide dinitrate sulfamethoxazole and trimethoprim, guinidine prazosin, clofibrate sucralfate and pentoxifylline. The leaflets provide the patient with:

- a description of the contents
- a list of the diseases for which the drug is used as a treatment
- information the patient should tell the physician before taking the medication
- dosage information—how the medication should be taken
- instructions on what to do if a dose is missed
- possible interactions with other medications
- possible serious and non-serious side effects

In 1991, MILs that were revised and updated included: Probenecid, Nitroglycerin, and Ranitidine/Famotidine.

HYPERTENSION SURVEY

The FDA designed and supervised the data collection of a survey to assess information needs and motivations of subgroups of older individuals with hypertension who subscribe to the AARP Pharmacy Service. Analyses identified four distinct sub-audiences who are expected to respond differently to varying health promotion message strategies. A manuscript entitled "A Segmentation Analysis of Prescription Drug Information-Seeking Motives Among the Elderly" has been prepared and submitted for presentation at the 1992 Marketing and Public Policy Conference to be held in Washington, D.C., May 15-17, 1992. Subsequent to the completed data analyses, targeted messages will be developed and tested on identified sub-audiences.

PRESCRIPTION DRUG HANDBOOK

In early 1990, the FDA assisted in the review and editing of the AARP Pharmacy Service Handbook. AARP expects to take the Handbook to press by mid-1991.

DRUG INTERACTION BROCHURE

In conjunction with the National Consumer's League (NCL) and other pharmacy related private organizations, the FDA has written a brochure about the drug interactions aimed mainly at the elderly consumer. This brochure explains to elderly consumers what drug interactions are, how to recognize them, and how to avoid them. The brochure was published in July 1990.

GENERIC DRUGS

The elderly in our population, as users of more medications than any other group, benefit greatly from the wide availability of generic drugs that generally cost much less than their brand name counterparts.

Landmark legislation, the Drug Price Competition and Patent Term Restoration Act of 1984, established an abbreviated procedure for FDA's review of marketing applications for a new class of generic drugs that exempts them from expensive re-testing for safety and effectiveness.

This testing was conducted originally for the brand-name drug and is thus not regarded as necessary for the generic copy. By lifting this testing requirement, the 1984 Act removed a major roadblock to the development of generics. Since enactment of the 1984 law, FDA has approved about 2,500 applications for generic drugs. During the past 12 months, approximately 299 abbreviated new drug applications have been approved. By comparison, before the 1984 law, the average annual rate of approvals was about 350 generic products. According to trade groups, generic drug sales are expanding about 14 percent a year. FDA will continue to examine the impact of advertising, labeling, and education efforts on the elderly as more generic drug products are made available in the marketplace.

In September 1986, the Commissioner of FDA chaired a public workshop to review various topics associated with designing and conducting studies that are used to demonstrate that generic drugs are equivalent to performance to brand-name drugs. The purpose of the meeting was to determine whether FDA's testing regulations need updating in light of any new findings, in the scientific area that is relatively new and evolving. Maintaining a state-of-the-art capability in this area is regarded by FDA as critical to ensuring that generic drugs work as they are supposed to and provide the elderly and others with an effective lower cost alternative to brand-name medicines. A "TXi" Task Force was formed by FDA to study the issues posed at the workshop. The report of the Task Force was released in February 1988, and many of its recommendations have already been implemented.

In 1989, FDA made extensive efforts to resolve all uncertainties that may have been associated with the production of generic drugs and the manner in which they are approved. The Agency has revamped the management of the generic drug operations and put in place stricter controls on the way generic drug applications are processed. FDA is also conducting an extensive and vigorous investigation of the leading drug companies that manufacture generic products in an effort to assure the public of both the safety and efficacy of the generic drug supply in the United States. The Agency is reexamining many of the original drug applications, auditing samples of leading generic products to affirm that they meet specifications for marketing, and negotiating product recalls or application withdrawals where there has been any reason to be concerned that products on the market were not supported by valid data. The Office of Consumer Affairs has worked with the Leadership Council of Aging Organizations and other consumer organizations to address concerns and maintain consumer confidence by sharing timely and accurate information, reinforcing selected health messages, and providing updates on the Agency's action plan. The Agency has issued an interim finding that, in spite of the concerns, there has been no evidence that the generic drug products on the market have been compromised, and the public can continue to use these products with confidence.

APPROVED DRUG PRODUCTS WITH THERAPEUTIC EQUIVALENCE EVALUATIONS

In order to contain drug cost, virtually all States have adopted laws that encourage or mandate the substitution of less expensive therapeutically equivalent generic drug products for prescribed brand-name drugs. These State laws generally require that substitution be limited to drugs on a specific list or that it be permitted for all drugs except those prohibited by a particular list. In response to requests from the States for FDA's assistance in preparing drug lists that would enable them to implement their substitution laws, FDA published and continually updates the Approved Drug Products with Therapeutic Equivalence Evaluation list. This list identifies currently marketed drug products approved on the basis of safety and effectiveness by FDA under the Federal Food, Drug, and Cosmetic Act and provides information on all generic drugs that FDA had determined to be therapeutically equivalent to brand-name drugs. FDA believes that products considered to be therapeutically equivalent can be substituted with the full expectation that the substituted product will produce the same therapeutic effect as the prescribed product. The U.S. Pharmacopeia (USP) has distributed FDA's *Approved Drug Products With Therapeutic Equivalence Evaluation* as a third volume to their USP Drug Information publications. This cooperative venture with the USP will greatly enhance the availability of this FDA publication.

HEALTH FRAUD

Health fraud—the promotion of false or unproven products or therapies for profit—is big business. These fraudulent practices can be serious and often expensive problems for the elderly. In addition to 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, more often than the general population, are the victims of fraudulent schemes. Almost half of the people over 65 years of age have at least one chronic condition such as arthritis, hypertension, or a heart condition. Because of these chronic health problems, senior citizens provide promoters a large, vulnerable market.

In order to combat health fraud, FDA uses a combination of enforcement and education. In each case, the Agency's decision on appropriate enforcement action is based on considerations such as the health hazard potential of the violative product, the extent of the product's distribution, the nature of any mislabeling that has occurred, and the jurisdiction of other agencies.

FDA has developed a priority system of regulatory action based on three general categories of health fraud: direct health hazards, indirect hazards, and economic frauds. When a direct health hazard is involved, FDA takes immediate action—seizure, injunction, or recall. When the fraud does not pose a direct health hazard, the FDA may choose to concentrate more on education and information efforts to alert the public. Both education and enforcement are enhanced by coalition building and cooperative efforts between Government and private agencies at the national, State, and local levels. Also, evaluation efforts help ensure that our enforcement and education initiatives are correctly focused.

The health fraud problem is too big and complex for any one organization to effectively combat by itself. Therefore, FDA is working closely with many other groups to build national and local coalitions to combat health fraud. By sharing and coordinating resources, the overall impact of our efforts to minimize health fraud will be significantly greater.

FDA and other organizations have worked together to provide consumers with information to help avoid health fraud.

In 1986, FDA worked with the National Association of Consumer Agency Administrations (NACAA) to establish the ongoing project called the NACAA Health Products and Promotions Information Exchange Network. Information from FDA, the Federal Trade Commission (FTC), the U.S. Postal Service (USPA), and State and local offices is provided to NACAA periodically for inclusion 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.

Since 1989, four regional health fraud conferences have been held in the U.S. and Puerto Rico; Los Angeles (Culver City), CA; and Carolina, Caguas, and Ceiba, Puerto Rico.

In 1990 and 1991, FDA's Public Affairs Specialists all over the country have carried out extensive campaigns against health fraud, particularly targeting senior groups. These efforts have included radio and television shows and public service announcements, talks, and workshops.

REGIONAL HISPANIC HEALTH FRAUD CONFERENCE

FDA has made special efforts to target health fraud information to Hispanics, particularly the elderly. As a special population, they are particularly at risk because of language and cultural considerations that may limit their access to health care and information about health fraud.

The Hispanic Health Fraud Initiative was kicked-off at the model 1989 National Health Fraud Conference of San Juan, PR. The primary conference goal was to provide practical guidance to individuals and organizations in the Commonwealth that would enable them to recognize and defend themselves against health fraud, quackery, and misinformation.

FDA has conducted a series of followup regional conferences throughout Puerto Rico and the continental U.S. The series began in Puerto Rico in September 1990 in the Carolina Region. In 1991, the series was continued in Caguas, Fajardo, Ceiba, and Humacao. These conferences were cosponsored with the Congress of Workers and Consumers of Puerto Rico (COTACO) and the Puerto Rico Department of Consumer Affairs. The first in the statewide series of conferences was held in FDA's Pacific Region (Culver City, CA), on September 13-14, 1990. Two additional state-

wide conferences are being planned for 1992 in FDA's Southeast Region in Miami, FL, and in the Southwest Region in Sante Fe, NM.

"HEALTH IS LIFE" CONSUMER EDUCATION CAMPAIGN

FDA, the Food Marketing Institute (FMI), and the National Urban League (NUL) launched a cooperative consumer health education campaign which is culturally specific (language and graphics) and focused to promote healthy lifestyles among African Americans. The campaign components include seven nutritional and health promotion posters that are culturally specific to the African American community. The posters promote good health behaviors and are targeted to the following African American audiences: elderly and young males; pregnant women; children 6 to 12 years of age; adolescents 12 to 17 years of age; and the general population.

The campaign was unveiled at the July 1991 annual convention of the National Urban League and has been promoted through over 150 other national African American multiplier organizations, such as the Auxiliary to the National Medical Association; National Council of Negro Women; LINKS, Inc.; Delta Sigma Theta Sorority; and the Congressional Black Caucus. The NUL's affiliate network of 114 local organizations are displaying and promoting them to their respective constituencies along with promoting the relationship between diet and health. An additional 3,000 copies of the posters were provided to the FMI membership for display in member food store chains.

ACTIVITIES OF PUBLIC AFFAIRS SPECIALISTS

Mammography, an x-ray examination of the breast used as a screening tool in the detection of breast cancer, is the best method currently available for detecting tumors in their early stages, offering women their best chance for survival.

To inform women and health care providers about mammography and the early detection of breast cancer, FDA's Office of Consumer Affairs (OCA) and the Center for Devices and Radiological Health (CDRH) initiated an education campaign when focused on the need to select a quality mammography facility.

In 1990, the OCA and CDRH continued their educational efforts in providing information on mammography. A breast cancer and mammography packet were mailed to 10,000 consumer organizations and individuals. The packet included material, developed to inform women and health care providers about mammogram, a "Mammography Screening Update" providing guidelines for the detection of breast cancer in women without symptoms and current bibliography of publications on breast cancer available from the National Cancer Institute.

A comprehensive story on hearing aids by a Public Affairs Specialist in an Orlando, FL, newspaper elicited over 1,000 requests for information, sparking a nationwide initiative by FDA field offices to bring more information on these devices to the public.

OCA is working with the Philadelphia and Newark District Offices to pilot a consumer education program called Pharm-Assist, designed to deliver prescription information to elderly, disadvantaged, non-English speaking, and minority consumers. Consumer HELP, and independent consumer group, and Ciba-Geigy, a manufacturer, are supporting this initiative.

FOOD LABELING

On November 27, 1991, FDA published (Federal Register 56(229):60366-60891) a final rule regulating nutrition labeling of 20 of the most frequently consumed raw fruit and vegetables and fish. In addition, 22 proposals published that same day addressing other aspects of nutrition labeling as directed by the Nutrition Labeling and Education Act of 1990. Three proposals deal with such specifics as mandatory nutrition labeling, which includes the listing of total calories, calories derived from fat, total fat, saturated fat, cholesterol, total carbohydrate, complex carbohydrates, sugars, dietary fiber, protein, sodium, vitamin A and C calcium and iron. The document also includes two types of reference values (Reference Daily Intakes (RD) and Daily Reference Values (RDV)) that consumers can use as an up-to-date yardstick for making healthy dietary choices. Another important proposal is the nutrient content descriptor document that defines the nine core descriptor terms, free, low, high, source of, reduced, light (lite), less, more, and fresh. Among the proposals was the document defining serving sizes for 131 food categories. Additionally, proposals addressing FDA's requirements for the use of health claims on food labels by manufacturers to advertise purported advantages of their products. The public has 90 days from the date of publication to comment on these documents. These proposals are expected to be finalized by November 8, 1992.

TOTAL DIET STUDIES

The Total Diet Study, as part of FDA's ongoing food surveillance system provides a means of identifying potential public health problems with regard to diet for the elderly and other age groups. Through the Total Diet Study, FDA is able to measure the levels of pesticide residues, industrial, chemicals, toxic elements, and nutritional elements in selected foods of the U.S. food supply and to estimate the levels of these substances in the diets of eight age-sex groups (6- to 11-months infants, 2-year-old children, 14- to 16-year-old boys, 14- to 16-year-old girls, 25- to 30-year-old females, 25- to 30-year old males, 60- to 65-year old females, and 60- to 65-year-old males). Because the total Diet Study is conducted yearly, it also allows for the determination of trends and changes in the levels of substances in the food supply and in daily diets.

The Total Diet Study is being modified to reflect the latest food consumption information. The revision will also add about 15 more foods and will include data to calculate dietary exposures for men and women aged 70 and older.

POSTMARKET SURVEILLANCE OF FOOD ADDITIVES

FDA's Center for Food Safety and Applied Nutrition receives and evaluates approximately 1,500 reports of adverse reactions to food and food additives each year. Of the complainants who reported their age, 12-15 percent were individuals over age 60.

PROJECT ON CALORIC RESTRICTION

FDA is participating in research which could lead to significant insight into the relationship between dietary habits and lifespan. The Project on Caloric Restriction (PCR) is a collaborative effort of FDA's National Center for Toxicological Research (NCTR) and the National Institute on Aging (NIA). It is designed to study whether a diet that is calorically restricted will add to the longevity and health of laboratory rats and mice. An increasing interest in the role of caloric restriction in aging coupled with the potential economic impact associated with health care was the impetus for the creation of the PCR.

The extraordinary interest displayed by research groups across the country and the NCTR's commitment to the PCR project has produced a scientific environment conducive to the interchange of ideas and the formulation of new approaches to the diverse scientific disciplines. NCTR developed a matrix which identifies areas of ongoing research, identifies additional research areas that need to be addressed and helps to avoid duplication of research effort.

Current study results from NCTR indicate that calorically-restricted animals are living longer than animals on unrestricted diets and are exhibiting a reduced incidence of all forms of spontaneous toxicity. In other words, caloric restriction may dramatically influence cancer development, toxic response, and biological processes usually associated with aging in animals.

Recent investigations in various laboratories agree that dietary caloric restriction is effective in extending average and maximum achievable life span in animals and in retarding a broad spectrum of age related disease processes, including spontaneously occurring and chemically induced cancers as well as that of many age associated noncancerous lesions.

DNA repair is increased in calorically restricted animals. Hormonal mechanisms may be responsible for the relative of this parameter. Oxidative free-radical damage appears to be decreased with caloric restriction in animals and perhaps in humans.

Caloric restriction does not appear to be harmful to behavioral functioning, and may be beneficial for some tasks. Effects of restriction on neural cells, especially hippocampal cells, need further evaluation.

Many of these results are consistent with the idea that caloric restriction induces an adaptation phenomenon within at least some animal species. Not all functions are altered. Rather those processes that appear to be most affected are those which have been previously referred to as longevity assurance processes. These processes have as their primary role maintenance of the information flow and content of biological systems and work in concert with one another with the end result being the multiple of these interactive changes. By fine tuning these processes, possibly via altering gene expression in some very basic way, animals may keep themselves alive until a more advantageous period for reproduction. By studying mechanisms of action, we can hopefully gain the advantages of this adaptation phenomena without its negative consequences and discomforts.

The collaborative project between NCTR and NIA is currently undergoing expansion in order to provide animals to more interested researchers and broaden the information base on biomarkers of aging and mechanisms of aging.

MEDICAL DEVICES OF PARTICULAR BENEFIT TO THE ELDERLY

Intraocular Lenses

Data on intraocular lenses (IOLs) continue to demonstrate that a high proportion (85 to 95 percent) of the patients will be able to achieve 20/40 or better vision with the implanted lenses and that few (3 to 5 percent) will experience poor visual acuity (20/200) or worse). The data also demonstrate that the risks of experiencing a significant post-operative complication are not great. Furthermore many of the complications result during the early post-operative period and are associated with cataract surgery; the incidence of these complications is generally not affected by IOL implantation. Approved lenses have a significant impact on the health of elderly patients having surgery to remove cataracts. The IOLs, because they are safe and effective, aid elderly patients by increasing the options available to maintain their sight and thus their ability to drive and otherwise lead normal lives. The cost of IOL implantation is competitive with other available options, particularly when the continuing cost of contact lens care accessories, such as cleaning and storage solutions, disinfection solutions, or heat disinfection units are considered, FDA continues to monitor several hundred investigational IOL models and has, to date, approved over 90 models as having demonstrated safety and effectiveness.

At the same time, FDA scientists are testing the optical quality of IOLs being marketed as investigational devices. FDA studies will include measurements of focal length, resolving power, astigmatism, and image quality. This information will provide a useful data base that can be factual in making decisions about optical quality of new IOL designs. Early test results show that the overall optical quality of currently marketed IOLs is good.

Due to the large number of IOLs now available, the situation that originally prompted concern from Congress and resulted in large adjunct investigations no longer exists, and the studies were phased out over a 3-year period beginning in 1986. An adjunct study is a clinical investigation peculiar to IOLs, which permits unlimited IOLs to be implanted under conditions requiring collection of adverse reaction data only. FDA permitted adjunct studies of IOLs in order to comply with provisions in the Medical Device Amendments created to ensure that IOLs would continue to be made "reasonably available" to physicians while data to support their safety and effectiveness were being collected. While the adjunct provisions have permitted widespread and immediate availability of new IOLs, they have provided little benefit from a safety monitoring of data collection perspective. In fact, the availability of large numbers of IOLs through the adjunct study have provided an incentive to firms to collect, analyze, and submit data to FDA in support of a premarket approval application.

Pacemakers

Dysfunction of the electrophysiology of the heart can develop with age, be caused by disease, or result from surgery. People with this condition can suffer from fainting, dizziness, lethargy, heart flutter and a variety of similar discomforts or ills. Even more serious life-threatening conditions such as congestive heart failure to fibrillation can occur.

The modern pacemaker is designed to supply stimulating electrical pulses when needed to the upper or lower chambers of the heart or with some newer models, both. It has corrected many pathological symptoms for a large number of people.

Approximately half a million elderly persons have pacemakers. At present, an estimated 125,000 pacemakers are implanted annually, 30 percent being replacements. An estimated 75 percent of these are for persons 65 years of age or older. Without pacemakers, some of these people would not have survived. Others are protected from life-threatening situations and, or most, the quality of life has been improved.

FDA, in carrying out its responsibilities of ensuring the safety and efficacy of cardiac pacemakers, has classified the pacemaker as a Class III medical device. Devices in Class III must undergo testing requirements and FDA review before approval is granted for marketing.

In addition, FDA in conjunction with the Health Care Financing Administration (HCFA) of the Department of Health and Human Services has instituted a national registry of cardiac pacemaker devices and leads. HCFA and FDA have developed an

operational registry with a data base of approximately 870,000 pacemaker and lead entries to date.

Physicians and providers of health care services must submit information to a national cardiac pacemaker registry if they request Medicare payment for implanting, removing, or replacing permanent pacemakers and pacemaker leads. The final rule implementing the national registry was published by FDA and HCFA in the July 23, 1987, Federal Register and became effective on September 21, 1987.

Under this new rule, physicians and providers of services must supply specified information for the pacemaker registry each time they implant, remove, or replace a pacemaker or pacemaker lead in a Medicare patient; HCFA may deny Medicare payment to those who fail to submit the required data. The information is submitted to HCFA's fiscal intermediaries at the same time as the bill for services and HCFA relays the data to FDA. Health care providers may obtain forms for submitting the information from the fiscal intermediaries.

The required information includes:

- The name of the manufacturer, the model and serial number of the pacemaker or pacemaker lead, and the warranty expiration date.
- The patient's name and health insurance claim number, the provider number, and the date of the procedure.
- The names and identification numbers of the physicians ordering and performing the surgery.

When a pacemaker or lead is removed or replaced, the physician or provider must also submit the date of initial implantation (if known) and indicate whether the device that was replaced was left in the body and, if not, whether the device was returned to the manufacturer.

Hemodialysis

End Stage Renal Disease (ESRD) patients are totally dependent upon dialysis treatment for survival until they receive a transplant, or if that is not possible, for the remainder of their lives. Moreover, ESRD is a disease of the elderly. Recent data released by the U.S. Renal Data System indicated that the median age adjusted for age and sex for new ESRD patients in 1988 was 60 with nearly 40 percent over 64. The incidence rates of ESRD vary dramatically among age groups, ranging from 1 in 91,000 below age 20, to 1 in 1,876 between ages 64 and 74.

Because of the nature of the treatment, patients are vulnerable to a number of possible hazards during dialysis. Many of the hazards arise from failure to properly maintain and use the equipment, or from insufficient attention to the safety of the dialysis system components. Educational programs are being conducted in several areas to alleviate these problems.

Following an educational video on human factors in hemodialysis, FDA in conjunction with organizations such as the Health Industry Manufacturers Association (HIMA), the Renal Physicians Association (RPA), and the American Nephrology Nurses' Association (ANNA) has been active in developing several additional videos and manuals. Complimentary videos illustrating concerns and proper techniques about water treatment and infection control have been distributed to every ESRD facility in the United States. These videos have received a very high level of acceptance from the dialysis community.

Last year a video on the proper reuse of dialyzers developed by the FDA, RPA, and other concerned groups was released. The video follows the protocols detailed in the Association for the Advancement of Medical Instrumentation (AAMI) Recommended Practice for the Reuse of Hemodialyzers. This practice has been adopted by the Health Care Financing Administration as a condition of coverage to ESRD providers that practice reuse.

A multi-State study conducted for the FDA in 1987 indicated that dialysis facilities appeared to be deficient in quality assurance (QA) techniques used in all areas of dialysis treatment. To address this problem, FDA funded a contract for development of guidelines that can be used by dialysis facility personnel in establishing QA programs. The guidelines printed in February 1991 were mailed to every dialysis facility in the U.S. area of charge.

In the past year, FDA has continued to work cooperatively with dialysis personnel and ESRD patients to improve the quality of dialysis treatment. Those efforts are yielding positive results.

Mammography

The FDA has over the years implemented programs directed at mammography that have resulted in improvements in the practice. Since 1975, FDA's Bureau of

Radiological Health (later, Center for Devices and Radiological Health) has conducted a great many mammography activities. These have been done with several goals in mind:

- reduce unnecessary radiation exposure of patients during mammography to reduce the risk that the examination itself might induce breast cancer;
- improve the image quality of mammography so that early tiny carcinoma lesions can be detected at the stage when breast cancer is most treatable with less disfiguring and more successful treatments;
- improve the ability of radiologists to read and interpret mammograms more accurately; and
- develop an integrated U.S. system of diagnosis and treatment of breast cancer, the risk of which increases significantly as a woman ages.

These activities have been conducted with extensive cooperative involvement with all 50 State Radiation Control Programs, with the American College of Radiology, with other key health professional organizations, with Federal agencies such as the Centers for Disease Control and the National Cancer Institute, as well as with several FDA components.

Radiological Health Sciences Learning File

There was also great concern about the accuracy of interpretation of the mammo-gram, primarily because the existing radiology residency training programs did not stress mammography. Consequently, in the early 1980's, BRH decided to help improve radiology training by adding a Mammography Section to the Radiological Health Sciences Learning File. The file is now used in essentially all U.S. Medical schools and radiology residency programs, as well as many others worldwide. Its films form the basis for the American Board of Radiology's credentialing examination.

THE MEDICARE SCREENING MAMMOGRAPHY BENEFIT

As the value of mammography became increasingly recognized, concern grew about the access of poorer women to this examination. To help solve this problem, the Medicare Catastrophic Coverage Act (MCCA) of 1988 added screening mammography as a benefit under Medicare. FDA was invited by the Health Care Financing Administration (HCFA) to assist in developing regulations to be met by facilities seeking reimbursement for screening mammography. The repeal of the MCCA, unfortunately, brought this effort to a halt, but the Medicare screening mammography benefit was revived by the Omnibus Budget Reconciliation Act of 1990. During late 1990, HCFA undertook an intense effort to modify the draft regulations into "interim final" regulations to go into effect by the January 1, 1991, effective date for the benefit. CDRH staff, along with the Centers for Disease Control and the National Cancer Institute personnel, have been heavily involved in assisting HCFA in this activity. The interim final regulations were published on December 30, 1990, and since then over 5,000 facilities have been certified by HCFA as eligible for reimbursement for screening mammography examinations conducted for Medicare eligible women. The certification has been initially based on the facility "self-arresting" that it is in compliance regulations but HCFA is developing facility inspection program that will be the basis for certification in the future. FDA is aiding HCFA in the development of the interpretative guidelines to be used by the inspectors. FDA is also aiding HCFA in the analysis of the comments received on the interim final regulations and in the development of final regulations.

THE NATIONAL STRATEGIC PLAN FOR THE EARLY DETECTION AND CONTROL OF BREAST AND CERVICAL CANCER

FDA, the National Cancer Institute, and the Centers for Disease Control have coordinated a combined effort by over 50 professional, citizen, and government groups to develop the National Strategic Plan for the Early Detection and Control of Breast and Cervical Cancer the Goal of this plan, a draft of which was presented to the Assistant Secretary for Health on October 1, 1991, is to mount a unified effort by all interested groups to combat these two serious cancer threats. FDA staff took the lead in writing the Breast Cancer Quality Assurance section, one of the six components of the plan, and participated in the development of the other components.

PATIENT NOTIFICATION ISSUES—1990

The Center for Devices and Radiological Health (CDRH), in collaboration with other FDA components, held a series of meetings with representatives of consumer

and patient advocacy groups, health professional organizations, and manufacturers to learn their views about firms directly notifying patients when a significant defect is discovered involving their particular type and model of cardiovascular implant. Six meetings around the country were held with cardiovascular implant patient and their facilities to discuss this issue.

For now, although FDA concentrated its inquiry on cardiovascular devices such as pacemakers, heart valves and defibrillator, the general concepts gleaned from this effort may apply to other implanted devices as well.

Results from the meetings show general agreement that:

- Direct patient notification by the manufacturer is desirable when a significant defect is discovered in a cardiovascular implant.
- Manufacturers should notify implanting and following physicians first, so they have time to prepare to counsel their patient.
- Manufacturers need to maintain up-to-date and complete registries to assure patient and physician traceability for notification purposes.

On November 28, 1990, the Safe Medical Devices Act of 1990 became law. Among other things, this law gives FDA the authority to require firms to directly notify patients when there is reasonable probability that a device will cause serious adverse health consequences or death. FDA can also require device firms to adopt a method of device tracking to ensure that patients can be notified under such circumstances.

Blood Glucose Monitors

Recent publications estimate the number of diagnosed diabetics in the United States to be 5 million and increasing at a rate of 600,000 per year. Over 65 percent of diabetics are 55 years old and, of course, many must monitor their blood glucose.

Since the implementation of Medical Device Reporting (MDR) regulations in December 1984, approximately 2,800 reports were submitted to FDA regarding performance problems encountered by users of self-monitoring blood glucose (SMBG) systems. As a result of these findings, a project was initiated to study and provide solutions to the problems with use of these devices. The study conducted in four phases: (1) information/data analysis including labeling, instructional and training materials; (2) identification of problems and contributing factors, including the use of data obtained by survey, contract, scientific literature, laboratory testing and MDR submissions; (3) development of a strategy for corrective action(s); and (4) implementation of corrective actions that could include assistance and collaboration with interested organizations.

As the limitations of the elderly, e.g., slowed response time, deficient vision, etc., are important considerations in properly using glucose meters, FDA conducted a human factors analysis of blood glucose meters. Completed in May 1990, the goals of the analysis were:

- determine of operation and instructional materials of blood glucose meters is compatible with users' ability
- determine if the features of blood glucose meters contribute to user error; and
- determine the quality and quantity of instructional material available to meter users for learning proper meter operations.

A National Steering Committee for Quality Assurance in Capillary Blood Glucose monitoring was recently formed to address findings of the human factors study. During FY 1991, the Committee initiated development of user education strategies and instructional material designed to reduce problems associated with the use of blood glucose meters.

Patient Restraints

Soft patient restraints are devices used to protect patients from falls and other injuries. Restraints are used mostly on elderly patients. FDA's Medical Device Reporting (MDR) database has documented nearly 40 deaths related to patient restraint use. The scientific literature suggests that the annual deaths related to use of this device may be as high as 200. Moreover, the use of patient restraints is expected to increase as the number of elderly persons increases. FDA believes that the users of these devices, primarily nurses, nursing assistants, and nurses aides need better instructional materials to be able to use these devices properly. Accordingly, FDA initiated an educational campaign aimed at development of:

- graphic messages to be used on the restraints and in the package labeling to effectively convey important safety information to restraint users
- a poster to serve as a reminder to crucial information needed to apply restraints properly

- a brochure and exhibit for use at professional meetings; and
- a learning package to assist facilities in meeting on-going educational needs.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration (HRSA) has lead responsibility for Federal efforts to promote access to health care services, primarily through programs which increase the availability of community health resources.

HRSA's programs are far-reaching in their support of health services to disadvantaged and underserved groups. In addition to older people, our clients include mothers and children, minorities, the homeless, the poor, drug users, migrant workers, people with AIDS/HIV, those with Hansen's Disease, and those who need organ transplants. Our challenge is to help assure the best possible care to as many individuals as possible at reasonable cost.

HRSA also provides technical assistance and resources to improve the education, supply, distribution and quality of the Nation's health professionals, and access to health services and facilities. Our partners in these efforts include State and local health departments, universities, private nonprofit organizations, and many other participants in the Nation's public health care system.

A primary emphasis during the past year has been on strengthening the role of State and local health departments. The HRSA Administrator, Robert G. Harmon, M.D., M.P.H., has emphasized the need for HRSA to link its primary care programs, such as Community Health Centers with State and local health departments. In an effort to facilitate this coordinated effort, Memoranda of Understanding were signed with the three public health associations, the Association of State and Territorial Health Officials (ASTHO), the National Association of County Health Officials (NACHO), and the U.S. Conference of Local Health Officers (USCLHO). ASTHO is now assisting states and HRSA in assessing primary health care needs. USCLHO is assisting local governments in improving the health status of minorities and assessing HIV service demands placed on rural and smaller health care systems.

HRSA is concerned about training our Nation's professionals to provide care for today's older individuals and individuals who will be old in the future. The Agency provides services to underserved older Americans, such as those who live in rural areas and those with low incomes. One-quarter of older Americans live in rural areas. One out of four elderly Americans, or 7.4 million, are poor or near poor.

Several HRSA components significantly influence programs and activities that benefit older Americans.

BUREAU OF HEALTH CARE DELIVERY AND ASSISTANCE

The Bureau of Health Care Delivery and Assistance (BHCDA) helps assure that primary health care services are provided to persons living in medically underserved areas and to persons with special health care needs. It also assists States and communities in arranging for the placement of health professionals to provide care in health professional shortage areas. The Bureau provides services to older Americans through Community and Migrant Health Centers (C/MHCs or Centers), the National Health Service Corps, the Division of Federal Occupational and Beneficiary Health Services, the Home Health Demonstration Program, and the Health Care for the Homeless Program.

COMMUNITY AND MIGRANT HEALTH CENTERS

In fiscal year 1991, a total of 539 C/MHCS, located in medically underserved areas, provided a range of family-oriented, preventive, primary care managed care services to those who would otherwise lack access to care, particularly the poor and minorities. Approximately 5.8 million people were served, of which over 7 percent (or about 431,890) were age 65 or older.

The cooperative program between HRSA and the Administration on Aging (AoA) is near completion. The purpose of the collaborative project is to improve the delivery of primary health care to older persons by establishing linkages among area agencies on aging (AAAs), community and migrant health centers, and other types of health care agencies. Training was given to AoA and Primary Care Association (PCA) staff to assist them in developing statewide plans for health services to the elderly. An evaluation of the training that began in fiscal year 1989, has been completed. Several State Primary Care Associations have projects with AAAs for mutual referrals and outreach.

The HRSA and AoA have conducted an evaluation of the activities under the collaborative project. The evaluation produced case studies on the development of link-

ages between the PCAs and the AAAs and statewide planning efforts. Findings of the case studies showed that financial barriers, particularly obtaining third-party reimbursements from Medicare, were the major impediments to increasing elderly participation in C/MHCS. With respect to Medicare, these Centers indicated several barriers, such as the following: the level of reimbursement is not enough to cover costs of care, the cost of processing is too high relative to reimbursement, and administrators, in some instances, are not fully knowledgeable about processing for reimbursement.

The evaluation also indicated the desirability and acceptability of the linkages by the State, local and Federal agencies. Most of the AAAs and PCAs involved in the case studies have adopted agreements to improve the acceptability of services to the elderly by more thoroughly refining and marketing the services. The final report includes both an analysis of collaboration efforts, and a manual on enhancing Medicare reimbursement to community and migrant health centers. These documents will be useful to C/MHCS, AoA and others interested in collaborating on enhanced services for the elderly.

THE NATIONAL HEALTH SERVICE CORPS

The National Health Service Corps places physicians, nurse practitioners, physician assistants, certified nurse mid-wives, and other health professionals in health personnel designated shortage areas. Older Americans with special health needs and reduced mortality need primarily care providers close at hand. The Corps works closely with C/MHCS, other primary care delivery systems and the Indian Health Service to provide assistance in recruiting and retaining health personnel for populations in need.

DIVISION OF FEDERAL OCCUPATIONAL AND BENEFICIARY HEALTH SERVICES

The Division of Federal Occupational and Beneficiary Health Services (DFOBHS) provides a variety of services related to health promotion and disease prevention in the elderly to managers and employees of over 3,000 Federal agencies. Retirement planning, care of aging parents, and prevention of osteoporosis are some examples of geriatric issues that are regularly addressed in educational seminars and counseling sessions provided by the Division's clinical and employee assistance programs.

HEALTH CARE FOR THE HOMELESS PROGRAM

In calendar year 1990, through the Health Care for the Homeless Program, primary health care, outreach, substance abuse, mental health and case management services were provided to 393,099 homeless individuals, of which 3 percent were aged.

HEALTH CARE IN THE HOME PROGRAM

The Health Care in the Home Demonstration Program is targeted for low-income, highly vulnerable individuals who can avoid lengthy stays in hospitals and other institutions. The Bureau has awarded \$2.9 million in fourth year funding for this demonstration program which has been authorized for 6 years. A multidisciplinary team approach is a central feature of the five-State program.

The project is continuing to demonstrate that many low-income uninsured individuals at high risk for multiple hospitalizations or institutionalization can best be medically served in the home. The project has awarded funds to five State grantee agencies (Hawaii, Utah, North Carolina, South Carolina and Mississippi) to demonstrate and evaluate the Program. The grantees identified eligible recipients to participate in the program of which at least 25 percent of those receiving care are 65 years or older. In the fourth year, 10 percent must be 65 years of age or older.

The demonstration program is oriented toward case management and service delivery. The multidisciplinary team approach remains as the primary focus of the program. It involves a comprehensive continuum of efficient, effective, and qualitative home care provided by a team of health professionals appropriate for each patient case. As part of the demonstration, North Carolina will be studying the role of the pharmacist as part of the multidisciplinary team. In the first year of funding, the grantees emphasized the design of their specific program. Primary focus was on formalization and start-up costs associated with a new program. The second year of funding primarily entailed the implementation of services. During the third year, the five programs were operating at full capacity. During the fourth year some innovative studies of case management will begin.

A contract for the Demonstration program evaluation over the first 3 years was awarded and a second contract for the fourth through sixth years is being devel-

oped. The evaluator is responsible for data collection and analysis to permit a descriptive review of the program. Technical assistance contracts for program development and implementation have been awarded and another is planned to assist evaluation efforts.

The Health Care in the Home Services Act program is demonstrating a State-administered centrally financed and locally operated public and private system of providing, coordinating, monitoring and evaluating a service delivery for in-home health care services.

OFFICE OF RURAL HEALTH POLICY

The Office of Rural Health Policy (ORHP) services as the focal point within the Department for coordinating nationwide efforts to strengthen and improve the delivery of health services to populations in rural areas. In particular, the Office advises the Secretary on the effects that the Medicare and Medicaid programs have on access to health care by rural populations, especially with regard to financial viability of small rural hospitals and the recruitment and retention of health professionals; coordinates rural health activities within the Department and with other Federal agencies, States, national organizations, private associations and foundations; administers a national grant program that establishes rural health research centers; provides staff assistance to the National Advisory Committee on Rural Health; and ensures that the Department invests adequate resources into research projects on rural health issues.

Aging related issues are of particular importance to the Office of Rural Health Policy. One quarter of the Nation's elderly live in rural areas and rural counties have, on the average, a higher percentage of their population over 65 years of age than their urban counterparts.

Activities and initiatives of the ORHP which affect the rural elderly include:

- providing an impact analysis to the Health Care Financing Administration on proposed and final regulations which are expected to have a significant impact on small rural hospitals and the rural elderly that they serve;
- supporting new and innovative local efforts to extend health care access to the rural elderly through a \$18.3 million Outreach Grant Program. The program targets elderly and others whose needs have heretofore gone unmet under existing federal programs;
- coordinating activities with the Bureau of Health Professions and the Bureau of Health Care Delivery and Assistance relating to the development and utilization of rural health professionals;
- meeting with personnel in other Federal agencies (e.g., the Alcohol, Drug Abuse and Mental Health Administration and the National Institute on Aging) to work on issues which affect the health and health care access of rural elderly; and
- apprising interest groups, such as the National Council on Aging and the American Association of Retired Persons about ORHP and its activities.

The Subcommittee on Health Services of the National Advisory Committee on Rural Health designated the needs of the rural elderly as one of three priority areas. Based on the work of the Subcommittee, the full Committee's 1991 report addresses a number of problems which rural elders experience in obtaining needed health services. The Committee proposes policy actions and programs to improve the availability of in-home services, community-based services, health promotion programs and transportation services, the adequacy of Medicare reimbursement for home health services, and the quality assurance of home health and institutional long-term care services. Also, the Committee recommends the issuance of specific regulations to implement the Medicare "social factors" provision contained in OBRA 1987. The provision directs Medicare's Peer Review Organizations to recognize "social factors" such as the distance from the patient's home to post-treatment care for complications as grounds for approving inpatient hospitalization for some treatment that would otherwise be on an outpatient basis.

Since 1989, the Office has awarded grants to seven rural health research centers to conduct applied research, case studies and analyses focusing on the delivery, financing, organization, and management of rural health and care services. The Centers provide data and policy research capabilities on a wide range of rural health concerns, including areas relevant to the elderly. Grants were awarded to: Rural Health Office of the Arizona Health Education Center, College of Medicine, University of Arizona, Tucson, AZ; Health Services Research Center, University of North Carolina, Chapel Hill, NC; Center for Rural Health Services, Policy on Research, University of North Dakota, Grand Forks, ND; WAMI Rural Health Research

Center, University of Washington, Seattle, WA; Marshfield Medical Research Foundation, Marshfield, WI; Department of Community Health and Preventive Medicine, Morehouse School of Medicine, Atlanta, GA; and Department of Preventive and Societal Medicine, University of Nebraska Medical Center, Omaha, NE.

To enhance the dissemination of information on rural health, an interagency agreement with the U.S. Department of Agriculture (USDA) was signed in January 1990. It provides for the placement of the Rural Information Center in the USDA's National Agricultural Library. This Rural Information Center Health Service (RICHS), as it is called, commenced operations on October 1, 1990. For access to the center, call 1-800-663-7701.

BUREAU OF HEALTH PROFESSIONS

The Bureau of Health Professions (BHP) provides national leadership to improve the training, distribution, utilization and quality of personnel required to staff the Nation's health care delivery system. BHP assesses the supply of and requirements for the Nation's health professionals and develops and administers programs to meet these requirements. It also collects and analyzes data and disseminates information on the characteristics and capacities of health professions production systems. The Bureau develops, tests, and demonstrates new and improved approaches to the development and utilization of health personnel within various patterns of health care delivery and financing systems. BHP provides financial support to institutions and individuals for health professional education programs, administers Federal grant programs for targeted health personnel development and utilization, and provides technical assistance to national, State, and local agencies, organizations, and institutions for the development, production, utilization, and evaluation of health personnel. These activities are carried out under the legislative authorities of Titles VII and VIII of the Public Health Service Act.

Fiscal year 1991 program activities contributing to the development of professional personnel to provide health care to the aged included:

- (1) Activities under training authorities targeted specifically for geriatric and gerontological education;
- (2) Activities under training authorities for primary care, nursing, and other health professionals where geriatric training may be provided as part of a broader educational emphasis; and
- (3) Data collection, studies, and other activities aimed at assessing and enhancing the qualifications of future health care providers to respond to the needs of the aged.

TARGETED SUPPORT FOR GERIATRICS

In FY 1991, 31 Geriatric Education Centers (GECs) received grants under section 789(a) of the PHS Act, an authority which specifically authorizes geriatric training. Many centers are consortia or other organizational arrangements involving several academic institutions, a broad range of health professions schools, and a variety of clinical facilities.

The Centers are based at the following institutions:

- University of Alabama at Birmingham, Birmingham, AL
- University of California, Los Angeles, CA
- Stanford University, Stanford, CA
- University of Southern California, Los Angeles, CA
- University of Colorado, Denver, CO
- University of Florida, Gainesville, FL
- University of South Florida, Tampa, FL
- University of Hawaii at Manoa, Honolulu, HI
- University of Illinois, Chicago, IL
- Indiana University, Indianapolis, IN
- University of Kentucky, Lexington, KY
- Louisiana State University, New Orleans, LA
- Harvard Medical School, Boston, MA
- University of Minnesota, Minneapolis, MN
- St. Louis University, St. Louis, MO
- University of Mississippi Medical Center, Jackson, MS
- Creighton University School of Medicine, Omaha, NE
- University of Medicine and Dentistry of New Jersey, Stratford, NJ
- University of New Mexico, Albuquerque, NM
- State University of New York at Buffalo, Buffalo, NY
- Hunter College, with Research Foundation of SUNY, New York, NY

Bowman Gray School of Medicine, Winston-Salem, NC
 Case Western Reserve University, Cleveland, OH
 University of Oklahoma, Oklahoma City, OK
 Oregon Health Science Center, Portland, OR
 University of Pennsylvania, Philadelphia, PA
 Meharry Medical College, Nashville, TN
 Baylor College of Medicine, Houston, TX
 University of Texas, San Antonio, TX
 Virginia Commonwealth University, Richmond, VA
 University of Washington, Seattle, WA

Awards for these 31 GECs totaled \$9,493,820 for fiscal year 1991. Funding for fiscal year 1992 under section 789(a) is expected to be approximately \$9,688,000. These Centers are educational resources providing multidisciplinary geriatric training for health professions faculty, students and professionals in allopathic medicine, osteopathic 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 educational community within designated geographic areas. Activities include faculty training and continuing education for practitioners in the disciplines listed above. The Centers also provide technical assistance in the development of geriatric education programs and serve as resources for educational materials and consultation.

GERIATRIC ACTIVITIES SUPPORTED UNDER BROADER TRAINING AUTHORITIES

Division of Associated, Dental and Public Health Professions

This Division funds education projects for a wide array of health providers. The General Dentistry Training Grant Program (section 785) currently supports 36 postdoctoral residency and advanced education programs in dentistry, which include training opportunities to provide dental care to the elderly. In awarding \$3,787,000 in FY 1991 grants, a funding priority was given to applicants who proposed to further expand and improve the geriatric training components of their postdoctoral programs.

Under section 799A, the grant program for Interdisciplinary Training for Health Care for Rural Areas has as one of its goals improving access to and availability of health care for the residents of rural communities. A funding priority for this grant program is given to applicants who include curriculum elements that address the uniqueness of health conditions and the ethnic/cultural characteristics of the populations within the rural areas where training/service is occurring. This provision includes the health of older Americans, and is reflected generally in funded projects.

The University of Hawaii at Manoa School of Social Work received \$149,812 for a project cosponsored by the Hawaii Department of Health. The project is establishing a statewide coordinated structure for rural health care providers and interfaces with the Pacific Islands Geriatric Education Center and Area Agencies on Aging. Activities will increase the knowledge base of providers on the needs of special rural populations, including the elderly.

The University of Nebraska Medical Center College of Dentistry received \$129,976 for the development of clerkships of rotating interdisciplinary training experiences in rural Nebraska. This project, which involves significant geriatric emphasis, will provide special didactic course work in the social aspects of health care delivery to elderly and ethnic minority individuals, including migrant workers. Collaborative arrangements exist with the Nebraska Department on Aging and the Nebraska Geriatric Education Center. Existing area training sites serving a significant population of elderly persons will be used in the implementation of project objectives. The evaluation team includes representatives of the Omaha Gerontology Program.

The University of North Dakota School of Medicine received \$194,019 for a project which proposed to increase recruitment and retention of nurse practitioners, physician assistants, and social workers in designated health manpower shortage and frontier areas of North Dakota. Continued education for practitioners in isolated areas through the use of teleconferencing will include topics such as alcoholism in the elderly and the impact of geographic isolation upon the management of Alzheimer's Disease among the elderly.

Vanderbilt University received \$187,457 to establish a nurse case-managed primary care clinic to serve as a clinical practicum site for graduate nursing and pharmacy students as well as family practice residents. The clinic will serve a predominantly Black population and be used as a preceptored learning laboratory for geron-

tological nurse practitioners and gerontological psychiatric/mental health nurses, among others.

The West Alabama Health Services, Inc., received \$125,629 for a collaborative project with the University of Alabama to develop an interdisciplinary training program to enhance the quality and availability of health care services and to retain health care providers in the rural western part of the State. Trainees will undergo substantial interdisciplinary geriatric training.

Other grants awarded under section 799A include curriculum development and/or training seminars on gerontology and health care needs of the elderly.

Under section 788(b), the Model Education Projects Grant Program is intended to provide for the development and implementation of model projects in areas such as faculty and curriculum development and the development of new clinical training sites. This program gives a priority to proposals that are sensitive to the needs of special populations, including the chronically ill and minority aged.

The University of Illinois at Chicago College of Dentistry received \$87,586 for the second year of a project that is developing ways to enhance and test dental students' skills in geriatric dentistry through the use of standardized patients (SPs). Because SP behaviors are reproducible and consistent, they can be used to present selected cases, provide reliable feedback on student performance, and objectively test skills. SP cases will be developed by a team of dental educators, and geriatric dentists and physicians. Cases will be modified for use with other health care professionals.

The University of Maryland at Baltimore Geriatrics and Gerontology Education and Research Program received \$79,519 for the second year of a project to develop an educational model to train students to view health care needs of the elderly from a global, multidisciplinary perspective. Computer-simulated case learning programs will be designed to teach how to integrate and respond to information gathered.

The George Washington University School of Medicine and Health Sciences received \$129,620 for the second year of a project in which the Department of Health Care Sciences Division of Aging Studies and Services and the Department of Computer Medicine are developing a computer-assisted curriculum to teach geriatric medicine to medical and allied health students during their clinical training. The computer-assisted curriculum model (CACM) allows students to engage in problem-based learning and is designed to complement a concurrent clinical preceptorship in geriatrics. It also can be used as an independent educational intervention. It will allow medical schools without faculty trained in geriatrics to offer medical and allied health students a comprehensive, realistic geriatric medicine experience.

Allied Health Special Project Grants under section 796 have several purposes related to the aged: number 2—"to improve and expand enrollment in professions with greatest demand and most needed by elderly"; number 3—"interdisciplinary training programs that promote allied health in geriatrics and rehabilitation of elderly"; number 5—"adding and strengthening allied health curriculums in prevention and health promotion, geriatrics, long-term care, home health and hospice care, and ethics."

Several of these grant programs include activities to strengthen academic and clinical curricula in the areas of geriatrics and long term care, and to increase the geriatric knowledge and skills of their didactic faculties.

Howard University in Washington, D.C., has a \$103,274 grant titled "Multi-tiered Geriatric Education and Training Project." This grant addresses the need for geriatric literacy, interdisciplinary skills in response to the needs of the elderly, and strengthening curriculum units relative to geriatrics content throughout the College of Allied Health Sciences. The objectives of the grant are: (1) to impact the geriatric knowledge and skills of the didactic faculty; (2) to promote interdisciplinary geriatric care among clinical faculty; (3) to enable faculty to infuse geriatric content throughout the professional curriculum; (4) to impact student learning via January semester in geriatrics and subsequent geriatric experiential learning; and (5) establish faculty/student geriatric assessment teams.

Indiana University School of Medicine has a \$90,124 grant to strengthen existing curricula and expand enrollment in programs preparing allied health practitioners. Objectives include: (1) strengthening allied health programs through faculty development activities; (2) expanding enrollments which commonly serve the elderly (occupational therapy, physical therapy and respiratory therapy); (3) strengthening curricula in all nine allied health program areas offered by the Division of Allied Health Sciences and offering an interdisciplinary course in geriatrics for those professions which most commonly care for the elderly; and (4) enhancing recruitment to all the allied health programs through a series of health professions career days and guidance counselor information sessions with special emphasis on minority re-

cruitment through the establishment of a minority student association and minority mentor network.

Langston University in Langston, OK, a Historically Black College or University, received a \$108,904 grant titled "Enhancement of Faculty, Curriculum, and Students." Activities include strengthening academic and clinical curricula in the areas of health prevention and promotion, geriatrics, long-term care, home health, and hospice care.

Clark County Community College has a \$88,222 grant titled "A Wellness-Centered Geriatrics Specialist Program." This grant is designed to implement an interdisciplinary modular approach to address allied health care training to serve the needs of an aging population. Objectives include: (1) developing interdisciplinary instructional modules on geriatrics for allied health practitioners and faculty that emphasize wellness and healthy aging; (2) delivering instructional modules to a minimum of 60 allied health practitioners and faculty; (3) providing a total learning environment for students in the geriatric instructional modules to gain a more positive attitude about aging and increased willingness to work with the senior adult client; and (4) developing continued community support.

DIVISION OF MEDICINE

The Division continues to support through its grant and cooperative agreement programs significant educational and training initiatives in geriatrics. More than \$14.3 million was awarded during FY 1991 for these efforts, which are estimated to have an impact on the training of 39,600 individuals.

Seventeen predoctoral grantees and 103 graduate program grantees under section 786(a), Family Medicine Training, indicated that they are actively involved in the development, implementation and evaluation of their geriatrics curriculum and training. Two of the predoctoral grantees received funds totaling \$152,591, and 28 of the residency program grantees received funds totaling \$1,782,779 specifically for developing and enhancing geriatrics curriculum and training experiences. These efforts will benefit 55 predoctoral students and 996 residents. In addition, 28 faculty development programs reported that they provided geriatrics training, benefiting an estimated 1,599 faculty. Six of the section 780 Family Medicine Departments program grantees received awards totaling \$450,887 for the purpose of strengthening geriatric training and carrying out research activities in this area.

Under section 784, the General Internal Medicine and General Pediatrics Residency Training Programs reported 15 grantees who provided geriatric medicine training to approximately 217 residents. A total of \$89,350 was awarded among 8 of the programs for their efforts. In addition to graduate training, 5 grantees under the faculty development program indicated that their geriatric emphasis would have an impact on 25 fellows or faculty, but no specific funds were received for these activities.

The Area Health Education Center (AHEC) Program (section 781) awarded a total of \$4.1 million to the 19 AHECs which indicated activities will benefit approximately 18,500 students and trainees. In addition, 10 AHECs received special initiative awards for programs targeted to health care issues of the elderly, including the reduction of substance abuse and medication mismanagement, treatment compliance, and to provide enhanced training experiences for residents in rural areas.

All 40 Physician Assistant Training Program (section 788(d)) grantees have instituted training activities in geriatrics. Funds in the amount of \$107,675 were awarded among 13 of the grantees specifically for their efforts in this area. This will have an impact on an estimated 2,500 trainees.

Ten grantees receiving support for Podiatric Primary Care Residency Training under section 788(e) authority have included curricular emphasis in geriatric health which will benefit an estimated 44 residents. These grantees received a total of \$659,259 for this purpose.

Under the program for Faculty Training Projects in Geriatric Medicine and Dentistry (section 789(b)), 16 grantees received \$3,891,539 to provide geriatric faculty training experiences for 36 physicians and 31 dentists. Participants were trained in either 2-year fellowships or 1-year retraining projects which included clinical, teaching, administrative, and research skills pertaining to geriatrics.

Geriatrics training components will be developed by 13 grantees under the Health Education and Training Centers Program (section 781(f)). A total of \$3.8 million was awarded for this purpose, and it is estimated that the training will benefit 15,500 health professionals.

DIVISION OF NURSING

The Division of Nursing continues to administer grants awarded through four programs: (1) Advanced Nurse Education, (2) Nurse Practitioner and Nurse-Midwifery, (3) Special Projects, and (4) Professional Nurse Traineeships. The fourth program provides funds to schools which allocate these funds to individual full-time master's and post-master's nursing students who are preparing to be administrators, educators, researchers, nurse-midwives, nurse practitioners, nurse anesthetists, or other types of nurse specialists.

Activities relating to the aging in each of these programs during FY 1991 include:

The Advanced Nurse Education Program (section 821) authority supported 10 grants totalling \$1,401,709 for gerontological and geriatric nursing concentrations in programs leading to a master's or doctoral degree in nursing.

Under the Nurse Practitioner and Nurse-Midwifery Program (section 822(a)) 15 master's or post-master's gerontological nurse practitioner programs received \$1,492,814 in grant support. The Nursing Special Projects Grant Program (section 820) supported 25 projects, amounting to \$3,252,965, which were related to gerontological nursing.

The Nursing Shortage Reduction and Education Extension Act of 1988 requires that 20 percent of program funds be used for projects dealing with geriatric nursing. In FY 1991, \$3,452,965 was spent on projects with a primary geriatric focus.

The grants continue to support efforts in the community as well as in institutions. Specific activities relate to support of target minority groups including rural black and Hispanic elderly, a Navajo patient/family teaching program, and a project to teach Indian nursing home personnel. Several projects address continuing education for registered nurses and other nursing personnel while others combine clinical experience with care of elderly persons in rural settings.

A total of 5,335 traineeships were supported through the Professional Nurse Traineeship Program (sections 830(a) and (c)). Of this number, 127 were for study in geriatric nurse practitioner programs and 147 additional traineeships were given to students who majored in care of aging persons. This represents approximately 5 percent of the total number of traineeships.

ACTIVE CONTRACTS UNDER TITLE VII AND VIII OF THE PUBLIC HEALTH SERVICE ACT

Funding FY 1991

Project

240-91-0014

University of Texas Health Science Center

"Seventh Workshop for Key Staff of Geriatric Education Centers"

04/06/91—04/08/92\$117,989

The purpose of the contract is to plan, develop, and conduct a workshop which will enable key staff from both long-existing and newly established Geriatric Education Centers to interact, and jointly consider GEC purposes. The workshop will focus on identification of strategies for accomplishing programmatic functions of GEC's including: faculty development, technical assistance, information referral, curriculum development, and education services in geriatric education. Emphasis will be given to identification and assessment of issues and solutions in GEC management and organization including methods: of obtaining support from the community or area served; for initiating and increasing geriatric content in health professions education programs throughout the area served; of stimulating the improvement of services to target populations; and investigating how GECs can address emerging issues in geriatrics.

Funding FY 1991

Project

91-442 (P)

University of Alabama, School of Medicine

"Impact Evaluation of Geriatric Education Centers"

05/07/91—11/06/91\$17,000

The purpose of this project was to assess the impact of training by Geriatric Education Centers (GECs) on their trainees, on the trainees' employing institutions, on the GECs themselves and on the GECs sponsoring institutions. The project utilized data

that were collected independently through all GECs by staff at the University of Alabama, Birmingham GEC (UABGEC). The data existed in raw form at UABGEC in questionnaires returned from four types of respondents solicited through the 41 GECs. Those respondents were GEC enrollees, supervisors, GEC directors and administrators of GECs' parent institutions.

Funding FY 1991

Project

240-90-0002

University of South Florida

"Sixth Workshop for Key Staff of Geriatric Education Centers—789(a)"

03/12/90—03/12/91 \$90,728

The purpose of this contract was to plan, develop, and conduct a workshop, including logistical support, which enabled key staff from both long-existing and newly established Geriatric Education Centers (GEC) to interact, exchange information, share strategies and jointly consider GEC purposes. The workshop focused on identification of strategies for accomplishing programmatic functions of GEC's including, but not limited to: faculty development; technical assistance; information referral activities; curriculum development; educational services in geriatric education; and other pertinent topics deemed appropriate.

Another focus was the identification and assessment of issues and solutions in Geriatric Education Centers management and organization including, but not limited to methods: of obtaining support from the community or area served; for initiating and increasing geriatric content in health professions education programs throughout the area served; of stimulating the improvement of services to target populations; and investigating how GECs can address emerging issues in geriatrics.

Funding FY 1991

Project

90-522 (P)

Gerontological Society of America

"A Protocol and Measuring Instruments for an Impact Evaluation of Geriatric Education Centers—301"

05/04/90—10/15/90 \$5,000

The Gerontological Society of American provided expert services in developing an evaluation protocol and necessary measuring instruments needed to conduct a national evaluation of the impact of the Geriatric Education Center grant program. This grant program has been funded since 1983 when four Centers were initiated. By 1990, 38 Centers were receiving Federal funds. While two evaluations of this program have been conducted, neither effort was focused on the impacts of these Centers on the infrastructure of geriatric education in the United States. Two major types of impact were assessed: (1) the impacts of GEC training and (2) the impacts of trainee professional activities resulting from GEC training on their respective institutions. The contractor consulted with experts in evaluation and in geriatric education to identify and clarify the nature and criticality of factors and issues that define impact of GEC education efforts. The factors and issues established the scope of information and data considered in developing and pilot-testing evaluation instruments.

Funding FY 1990

Project

90-934(P)

Daniel Zwick

"Geriatric Rehabilitation and Allied Health"

08/21/90-05/15/91 \$6,950

The purpose of this contract was to assess the recent, current, and projected rehabilitation activities of geriatric education centers, including all current or potential sources for program continuation, determined the extent to which allied health professions had been represented in those activities and ascertained the extent to which State legislatures and State supported health professions schools have demon-

strated an interest in perpetuating programs pertaining to rehabilitative health care for the elderly.

Funding FY 1990

Project

240-90-0046 Reimbursement Agreement with AHCPR
Research Foundation of State University of New York

"Diffusion of Medical Technology Using Geriatric Education Centers 301"

09/30/90-09/30/92\$480,408

The purpose of this project is to demonstrate and evaluate strategies for enhancing the speed and of adoption by physicians of a selected medical protocol intended for use with the elderly. The project will use Geriatric Education Centers (GECs) as vehicles for disseminating medical outcome findings and/or proposed guidelines for provider practice obtained from the Agency for Health Care Policy and Research (AHCPR). Before dissemination efforts are initiated, GECs will assess, in their respective geographic areas, such factors as knowledge about and use of the protocol and related protocols, attitudes relating to the protocol and health problems it is designed to address. GECs will demonstrate selected dissemination strategies and conduct follow-up assessments of use of the protocol and knowledge and attitudes relating to use of the protocol to address relevant health problems.

Funding FY 1988

Project

240-88-0034

Boston University Medical Campus, Office of Sponsored Programs

"Geriatric/Gerontology Curriculum for Preventive Medicine Residency Training Programs"

06/30/88-07/31/90\$282,529

This contract was awarded for development of a geriatrics/gerontological curriculum module for preventive medicine residency training programs. The project developed curriculum modules that provide the knowledge, skills and attitudes that preventive medicine residents will need to design, implement, direct and maintain preventive services for the elderly. The curriculum was field tested in three residency program, including one based in a health department. Resulting training materials will be distributed in the future to all general preventive medicine and public health residency training programs.

Funding FY 1988

Project

University of North Carolina at Chapel Hill

"Self-care Assessment of the Community-based Elderly" (Interagency Cooperative Agreement between the Division of Nursing and the National Institute on Aging)

08/05/88-08/04/91\$200,000

The project will provide a national sample database on self-care behaviors practiced by elderly persons in the U.S. not living in long-term care facilities. The database will be useful to a number of health and health related professions and service organizations whose efforts are directed toward assisting the elderly to continue to live in non-institutional settings for the maximum possible time through cost-effective health promotion and disease prevention interventions.

Publications

The "Seventh Report to the President and Congress on the Status of Health Personnel in the United States" (March 1990) has a section devoted to the Aging Population.

Two publications are now undergoing Department clearance prior to submission to the Congress. Each has a chapter on current issues relating either to geriatrics or the elderly.

"Eighth Report to the President and Congress: Health Personnel in the United States, 1991"

"Study Models to Meet Rural Health Care Needs Through Mobilization of Health Professions Education and Services Research" (May 1991)

NATIONAL INSTITUTES OF HEALTH—NATIONAL INSTITUTE ON AGING

INTRODUCTION

The National Institute on Aging (NIA) sponsors research on the full range of scientific disciplines, from the basic biology of cell growth to the study of intellectual function in older people. The Institute's mission is to better understand the complex processes that affect people as they age, which include the social attitudes and conditions of society at large. NIA programs emphasize studies on specific disorders that disproportionately affect older people. Already the results of Institute-funded studies are improving our ability to understand, diagnose, and treat such conditions as Alzheimer's disease, cardiovascular disease, osteoporosis, disability due to frailty and falls, incontinence, and sensory impairments. In addition, from this research we are learning more about the needs of special populations, such as older minority group members, older persons living in rural settings, and the fastest growing population group—the oldest old.

ALZHEIMER'S DISEASE

NIA RESEARCH ADVANCES

Alzheimer's Disease (AD) currently affects an estimated 4 million Americans. Manifested initially by mild forgetfulness, this devastating disease eventually progresses to erode all cognitive and functional abilities, leading to total dependence on caregivers and ultimately death. The prevalence of AD increases dramatically with age. Persons aged 65 to 74 have a 1 in 25 chance of having AD; while for those 85 and older, this likelihood rises to a staggering nearly 1 in 2 chance. This latter 85-plus age group is the most rapidly growing sector of the American population, portending a dramatic increase in the overall number of AD cases in the coming century.

Total annual cost to the Nation for the care of AD patients is estimated to be at least \$90 billion, including medical care, nursing home care, social services, early death, and lost productivity. The toll of caring for AD patients must also be calculated in terms of the burden on families and caregivers. The average duration of AD is 8 years, with more than 70 percent of patients with less severe disease cared for at home at an annual cost of \$12,000 each. The cost of nursing home care is more than double this figure, and most patients eventually spend some time in nursing homes. In addition, patients may be repeatedly hospitalized during the course of their illness, at greatly increased cost. Of course the burden is not solely financial; caregivers and family members may suffer from isolation, depression, and increased health problems, as well as financial strain.

Thus, AD presents a huge burden to the nation as well as a formidable challenge for the research community. In the face of this challenge, 1991 proved a tremendously exciting year in AD research. Major strides have been made in elucidating the possible causes of the disease. Most of this research has focused on understanding the origin of abnormal structures found in the brains of AD patients and the ways AD may interrupt normal patterns of functioning. Considerable research has also been focused on improved diagnosis and care for AD patients.

The NIH supports or conducts AD research through the National Institute on Aging, the National Institute of Neurological Diseases and Stroke, the National Institute of Allergy and Infectious Diseases, the National Institute on Deafness and Other Communication Disorders, the National Center for Research Resources, and the National Center for Nursing Research. Research highlights from these agencies follow this report. The National Cancer Institute; the National Heart, Lung, and Blood Institute; the National Institute of Dental Research; the National Institute of Child Health and Human Development; the National Institute of Environmental Health Sciences; the National Center for Human Genome Research; and the Office of the Director are also involved in AD research.

FUNDAMENTAL BRAIN STRUCTURES ARE CHANGED IN AD

The brain is the control center for our ability to move, to feel emotions and sensations, to reason, to speak and understand, to calculate numbers, and to form plans of action and carry them out, as well as for automatic functions such as breathing. The brain is composed of approximately 100 billion nerve cells (neurons), which re-

lated to each other in a vast communication network. Any individual cell may contact several thousand other cells, allowing for tremendous flexibility in the flow of information. These neurons are organized in regions of the brain which generally have different functions. The primary areas affected in AD patients are several regions of the cerebral cortex that form the outer layer of the brain and are thought to be responsible for cognitive functions such as language. The hippocampus, part of the cortex located deep within the brain and involved in memory functions, is also frequently affected.

Each nerve cell consists of a cell body (soma) and several extensions—the axon and dendrites. Axons carry messages from the soma to their terminals (endings), where they contact other neurons across gaps between cells called synapses. At the synapse, neurotransmitter substances are released from the axon termination. The neurotransmitter then makes contact with receiving cells, typically onto the dendrites. The resulting electrochemical changes at the receptor sites are carried as a message to the soma and then possibly on to other cells.

Within the soma, there are structures responsible for making and breaking down proteins, producing energy, transmitting messages, and regulating complex mechanisms of metabolism. The cell nucleus contains genes, the units of heredity. And internal cytoskeleton, composed of fibrous proteins, maintains the shape of the cell. One class of these fibrous proteins forms microtubules, which are responsible for transporting material between the nucleus and the end of the axon. Restructuring of the cell skeleton allows for formation of new synapses. The entire cell is enclosed in a semipermeable membrane. A distinguishing feature of neurons is that unlike other cells in the body, they are long-lived but cannot be replaced if they die.

Although it is not completely understood how AD interrupts the flow of information in the brain, many features of its neuropathology are now well established. Initial descriptions by Alois Alzheimer in 1906 of the brain of a patient with memory and other cognitive impairments showed several features, including atrophy of brain, tangled bundles of fibers within the nerve cells (now called neurofibrillary tangles or NFTs), and deposits, or plaques, of a then unidentified substance over the cortex, external to the cells (now referred to as senile or neuritic plaques).

The unknown substance in plaques was identified a decade ago as amyloid (specifically beta-amyloid), part of a larger protein, amyloid precursor protein (APP). APP resembles a membrane protein, with the beta-amyloid portion partially embedded within the membrane. It is not yet fully understood how the beta-amyloid is freed from APP. Substantial work is being done to solve this problem. One example is recent work by NIA-funded researchers, including Drs. Ralph Nixon at Harvard Medical School and Anne Cataldo at McLean Hospital in Massachusetts, which implicates a defect in the regulating action of certain enzymes (lysosomal proteases) involved in the breakdown of proteins, which may then lead to the release of beta-amyloid.

Similarly, researchers have only recently begun to clarify the genesis of the NFTs and possible mechanisms of cell death. In recent years, the main structural element of NFTs has been identified as paired helical (twisted) filaments (PHFs); a major component of these PHFs has been found to be a form of "tau," a protein normally forming the cytoskeleton.

The features identified by Alzheimer have remained the neuropathologic hallmarks of AD, though other abnormal aspects of the brain have since been reported, including amyloid deposition in blood vessels of the brain, reduction of the neurotransmitter acetylcholine in the cortex, defects in or reduced numbers of synapses, and changes in brain blood flow and metabolism.

Key research in 1991 has focused on: (1) genetic studies related to the APP gene and the production of beta-amyloid; (2) the creation of animal models of AD to elucidate the role of amyloid in the disease process; (3) the finding of a naturally occurring protein, substance P, which seems to halt the toxic effects of amyloid in experimental animals; (4) the nature of the NFTs; (5) defects at the synapse; (6) improved diagnosis of AD patients by standardized neuropathological assessment; and (7) evaluation of special care units for AD patients in nursing homes.

MUTATIONS IN THE GENE CONTROLLING APP ARE FOUND IN FAMILIAL AD

In up to 20 percent of cases, AD occurs in a familial form, in which many members of a family are affected by the disease. A number of families have been studied for the specific genetic defect responsible for this hereditary form of the disease.

Dr. John Hardy at St. Mary's Hospital in London in collaboration with NIA grantee Dr. Allen Roses at Duke University in Durham, NC, discovered a case of familial AD that showed a defect on chromosome 21 at the APP locus and caused by the substitution of a single amino acid (the "building blocks" of protein; here Valine

to Isoleucine). This site is near the region encoding part of the beta-amyloid sequence. This group of researchers then discovered the same mutation in another, unrelated family affected by hereditary AD.

This finding was strengthened by the work of Dr. Merrill Benson in collaboration with NIA grantee Dr. Bernardino Ghetti and others at the Indiana University School of Medicine and Richard L. Roudebush Veterans Affairs Medical Center in Indianapolis. This group had access to genetic material from three generations of a family with hereditary AD (two generations had brain specimens preserved on autopsy). A mutation was again found in chromosome 21, at the identical site found by Drs. Hardy and Roses, with a different amino acid substitution (here Valine to Phenylalanine). The ability of the defect to be inherited was demonstrated by the presence of the same mutation in members of two generations affected by the disease. The mutation was also found in members of the third generation, but they are still too young to develop AD.

Taken together these studies imply that a single genetic mutation within the chromosome controlling APP expression can lead directly to familial AD. This relationship clearly does not hold for all familial cases, as previous research showed different loci for genetic mutations leading to AD, including other loci on chromosome 21 and a defect on chromosome 19. The different loci of mutations found in earlier and current studies imply that there is heterogeneity in the underlying cause of even familial AD. It is also unlikely that a single mutation is responsible for the genesis of nonfamilial (sporadic) AD which makeup the majority of AD cases. However, this work underscores the importance of the gene for APP in the development of AD and sets the stage for the creation of animal models of AD by pinpointing a specific genetic locus that might be manipulated to produce AD in animals.

RESEARCHERS CREATE AN ANIMAL MODEL OF AD

The development of an animal model for AD would be invaluable. First, it would allow researchers to examine the progression of the disease, from earliest through final stages. In the case of humans, this is rarely possible, since most cases that come to autopsy are those of individuals severely affected by the disease. Animal models would allow scientists to study factors that may affect the nature and severity of the disease. In addition, new treatments could be studied in animals before they are tested in humans.

Historically, there has not been a good animal model of AD. However, recently a number of research groups have been able to use new genetic engineering techniques to create mice carrying the gene for beta-amyloid. Mice prove good candidates for the modeling of AD, since they are relatively inexpensive, have a short life span, and may be trained and tested on behavioral and cognitive measures.

NIA grantee Dr. Barbara Cordell and colleagues at California Biotechnology Incorporated injected newly fertilized mouse eggs with a form of the human APP gene. The eggs were implanted in foster mothers to develop. The offspring were then mated, producing a strain of transgenic mice carrying the human gene for APP. These mice displayed neuropathology that in some respects resembles human AD. Diffuse amyloid deposits (not in the form of plaques) were found in cortical and hippocampal regions of the brain (similar to sites of amyloid deposits in humans) and were located outside the cells, as in human AD. Since the mice studied were relatively young, it remains to be seen if the deposits develop into AD-like plaques. Dr. Cordell believes that the over-expression of APP leads to beta-amyloid deposition.

Drs. Shigeki Kawabata and Jon Gordon at Mt. Sinai Medical Center in New York City, and Dr. Gerald Higgins of the NIA Gerontology Research Center in Baltimore, MD, conducted a similar experiment in which mouse eggs were injected with a portion of the gene for APP containing the beta-amyloid region and the "C-terminal;" fragment. This fragment includes the portion of APP that ends within the cell and that has been shown to be toxic to cells in laboratory culture. A strong "promoter" was used to achieve high levels of expression of the gene. The young developed diffuse amyloid deposits. Older mice showed pathology similar to human AD, including neuritic plaques, NFTs, and widespread cell loss.

These two studies, as well as others using the transgenic mouse model, imply a strong tie between expression of APP and the development of AD-like pathology. The exact mechanism of this development is still unknown.

SUBSTANCE P MAY PREVENT TOXIC EFFECTS OF BETA-AMYLOID

Dr. Bruce Yankner of Children's Hospital in Boston showed in earlier studies that a portion of beta-amyloid was toxic to nerve cells and could be blocked by substance

P in laboratory culture. In a recent study co-funded by the National Institute of Neurological Disease and Stroke, Dr. Yankner and Neil Kowall of Massachusetts General Hospital in Boston injected beta-amyloid directly into the cortex and hippocampus of rats. On autopsy, these rats showed marked neuronal degeneration and A β -type changes in the regions of the injections. Next, these researchers injected substance P with the beta-amyloid into the rats' brains. Substance P is one of a group of naturally occurring proteins similar in structure to a portion of beta-amyloid. Substance P prevented the neuronal loss apparently triggered by beta-amyloid. Similar results were found when substance P was injected systematically. This study reaffirms the toxic effects of beta-amyloid and suggests that new therapeutic intervention trials with human AD patients may soon be possible.

CHANGES IN TAU MAY LEAD TO NEUROFIBRILLARY TANGLES

NIA researchers Drs. Virginia Lee, John Trojanowski, and colleagues at the University of Pennsylvania in Philadelphia have defined certain differences between the chief component protein of the paired helical filaments (PHFs) in NFTs found in AD. A component protein of PHFs called A68 and thought to be specific to AD, was isolated and purified from the brains of AD patients and analyzed for amino acid sequence. This sequence was found to be identical to that of normal tau, and no other protein components were present.

Abnormal changes in phosphorylation of tau may lead to the modified form, A68. Phosphorylation is the process by which highly charged phosphates are added to specific sites on proteins. This process has significant and diverse roles in cellular metabolism. The modified form of tau apparently prevents the effective binding of microtubules in the cytoskeleton and may lead to formation of PHFs.

SYNAPTIC LOSS CORRELATES WITH COGNITIVE IMPAIRMENT

Drs. Robert Terry, Robert Katzman, and colleagues at the University of California at San Diego have taken another direction in AD research. Rather than focusing on the role of amyloid plaques and NFTs, they examined the relationship of synaptic defects to cognitive measures in AD patients. Terry's group noted that in earlier studies only a weak correlation was found between neuropsychological scores of AD patients and the number of senile plaques and tangles in the brains of these patients found on autopsy.

In their study, Dr. Terry and colleagues compared scores on three measures of general cognitive ability with several neuropathological measures: loss of synapses, loss of neurons, numbers of NFTs and of plaques, and amounts of two neurotransmitters. They found a very high correlation between degree of synaptic loss and three cognitive measures. Plaques and tangles again correlated only weakly with the tests; correlations between neurotransmitter levels and cognitive measures were not significant.

These results seem to conflict with the central role given amyloid and plaque formation in many current studies. Dr. Terry suggests that the loss of synaptic structure is critical to the development of dementia. Plaques and tangles are important markers, but appear to be of secondary importance in the pathogenesis of dementia in these studies. In the view of Terry and colleagues, a possible cause of loss of synapses may be the failure of production or delivery of a trophic (growth- or maintenance-promotion) factor to the neuron, but they emphasize that there may be side-by-side mechanisms leading to the structural abnormalities of AD.

NATIONAL REGISTRY ON AD IMPROVES DIAGNOSIS OF PATIENTS

The Consortium to Establish a Registry for Alzheimer's Disease (CERAD) is now entering its sixth year. This NIA-funded program is working to develop uniformity of diagnosis in AD by bringing together information from physicians and scientists working at the 23 participating institutions. More than 800 AD patients and 450 normal subjects have been enrolled in the registry to date. These individuals are evaluated at entry into the program and annually thereafter. A primary goal of CERAD is the development of diagnostic measures to determine the presence, nature, and severity of the disease through clinical, neuropsychological, neuroimaging (magnetic resonance imaging), and neuropathological evaluations. To aid these efforts, the CERAD test battery has been translated into French, Spanish, and Dutch, with plans underway for translation into other languages.

Dr. Albert Heyman at Duke University Medical School in Durham, NC, and CERAD neuropathologists have developed a practical guide and standardized data forms for neuropathological assessment of AD. These instruments are particularly important because many autopsy reports of suspected AD patients either lack speci-

ficity in describing types of pathology found, or mix groups of patients with heterogeneous pathology, some of whom may have other dementing illnesses. Standard measures and a common language of neuropathology must be used to draw clear conclusions about AD and its stages.

The CERAD neuropathological assessment tool includes criteria for assignment of patients studied at autopsy into categories of normal, or of having "definite," "probable," or "possible" AD. These criteria are based on frequency of plaques found in tissue samples taken from at least five regions of the brain. This battery will lead to refinement of current diagnostic criteria by reducing subjective interpretation of brain changes found at autopsy and will allow accurate staging of the severity of the disease.

SPECIAL CARE UNITS FOR AD PATIENTS STUDIED

One important issue in the care of AD patients is whether those in nursing homes should remain among nondemented individuals or be placed in separate units designed especially to care for them. A study by Drs. Douglas Holmes, Jeanne Teresi, and Charlene Monaco at the Hebrew Home for the Aged in Riverdale, NY, studied the number and nature of separate, special care units (SCUs) through a survey sent to 2,678 nursing homes in five states. Of the 81 percent of homes that responded, 19 percent reported some type of specialized care for demented patients, either by geographic segregation (SCUs) or by grouping patients in mixed units with nondemented individuals (cluster units). Specialized care for both types of arrangements included modified nursing stations, additional nursing or other staff, special staff training, putting alarms on exits, cognitive stimulation for patients, and support groups for family and staff.

SCUs and cluster units were found to be similar in these measures, on criteria for admission to these units, such as level of dementia or behavioral problems; and both primarily admitted patients with severe impairments. When SCUs are analyzed together with cluster units, results of this study indicate that specialized care of some nature is provided by approximately 12 percent of nursing homes, an increase over earlier estimates of 7 to 8 percent. More patients with dementia, whether they are geographically isolated from nondemented patients or not, are receiving specialized care than previously believed.

RESEARCH ADVANCES IN ALZHEIMER'S DISEASE SUPPORTED AND CONDUCTED BY OTHER NIH INSTITUTES

NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE (NINDS)

The NINDS is the principal source of support for neurological research in the United States and a major participant in the study of AD. NINDS-supported scientists are pursuing a wide variety of research programs to expand the knowledge of this complex group of disorders. Basic studies re aimed at determining their underlying causes and effects, while clinical research extends physicians' skills at diagnosing and treating patients. The NINDS intramural and extramural research program in AD is a limited but highly focused endeavor addressing specific questions of significance to prevention and clinical care.

SCIENTISTS SEARCH FOR THE CAUSE OF AD

In the last year, NINDS-supported scientists used biochemical techniques that allowed them to measure the presence or absence of key proteins in both the amyloid plaques and NFTs. Such studies determined the major chemical components of these lesions and found distinct chemical differences between plaques and tangles. This finding may reflect a more widespread disruption of the nervous system than previously thought.

Since amyloid plaques seem to play an important role in AD, investigators are attempting to discover what role amyloid proteins play in the normal brain. NINDS-supported scientists have found evidence that APP may be an important regulator of growth and metabolism in cultured nerve cells as well as in the normal brain.

GENETIC CLUES FOUND TO BE THE CAUSE OF AD

As described in the main body of this report, AD may occur in a familial form. Previous studies of familial AD have revealed that this form of the disease may be linked to mutations at several loci on chromosome 21. NINDS-supported researchers have recently studied a number of families affected by the hereditary form of AD and found indications of a linkage between some cases of familial AD and a region

in chromosome 19. The scientists also collected additional data supporting the previously reported linkage between Familial AD and chromosome 21.

Scientists at the NINDS have been studying a German family with 21 members affected by AD. The investigators traced the disorder back through six generations to a couple residing in Westphalia during the middle of the 19th century. The data collected during this study indicate that the inheritance pattern is most consistent with genetic transmission through an autosomal-dominant mechanism. Discovering such patterns of inheritance can help scientists zero in on the gene or genes that cause familial AD and help them develop better tests to indicate who is at risk of developing the disease.

INVESTIGATORS SEEK MORE SPECIFIC DIAGNOSES AND TREATMENTS

The diagnosis of AD remains a diagnosis of exclusion of other causes of dementia, and certainty that a patient has AD can only be reached through examination of the brain tissue after death. Differential diagnosis is a critical issue; for example, NINDS studies indicate that 25 percent of dementia is due to cerebrovascular disease and is not presumably of the Alzheimer's type. NINDS-supported scientists are using advanced brain imaging technology such as positron emission tomography (PET) and magnetic resonance imaging (MRI) to find markers that can help scientists study AD in living patients.

The diagnosis of AD is made more difficult by the fact that some of its traits, such as memory dysfunction, can result from other disorders. In order to improve diagnostic measures, NINDS intramural scientists have compared memory and analytical capabilities in demented patients who had either Parkinson's disease or AD. They found that although the AD patients performed more poorly on memory tasks, they also had dysfunction in analytical skills of the type usually found in Parkinson's patients. Parkinson's patients showed poor analytical skills of the kind typically found in this disorder, but also had memory troubles of the type usually associated with AD. This pattern suggests that there is some overlap between traditional diagnostic categories for these diseases.

Currently, once a diagnosis of AD is made, doctors can do nothing to slow or halt the degeneration of the brain, although a few therapeutic drugs are being examined. Major symptoms of Parkinson's disease have long been treated with replacement of the neurotransmitter dopamine, but similar attempts to replace cholinergic neurotransmitters—brain chemicals that are less abundant in AD patients—have shown little or no success. Studies by NINDS-supported scientists indicate that these neurotransmitters do not bind normally to their neuronal receptors in AD patients. This problem may account for the failure of cholinergic replacement therapies. Measurement of the reduced binding of these neurotransmitters may also provide a marker of the severity of the disease.

Investigators have previously suggested that nerve growth factor (NGF) might protect the brain against the neuronal loss found in AD and other degenerative disorders of the brain. NINDS-supported investigators have now successfully used mouse NGF and human NGF to protect cholinergic neurons in rats from degenerating after an incision has been made in part of the brain. These studies prepare the groundwork for further research in rodents and nonhuman primates that may lead to greater understanding of the preservation of still active brain cells in humans with neurodegenerative disorders.

ANIMAL MODELS DEVELOPED FOR THE STUDY OF AD

Further work on development of animal models to elucidate the process underlying cellular and chemical changes in AD has been carried out by NINDS-funded researchers. Scientists have extended previous observations that aged monkeys have brain plaques composed of material that is highly similar to that found in the brains of people affected by AD. Aged monkeys also have abnormal nerve fibers much like the NFTs found in the brain tissue of AD patients. In further experiments, aged monkeys exhibited varying degrees of impairment in memory and other cognitive functions.

STUDIES FOCUS ON DEFINING WHO IS AT RISK

Investigators working with support from the NINDS have discovered that first-degree relatives of patients with AD are at greater risk for the disease than their peers in the population at large. However, they also found that relatives of patients with Parkinson's disease were at increased risk for developing AD. The investigators suggest that the increased risk of AD may not be specific only to relatives of

patients with AD, but that the first-degree relatives of people with other neurological disorders may also be at risk.

This year, in an NINDS-supported study that evaluated parental age as a risk factor for AD, scientists found preliminary evidence that younger fathers appear to have a much higher risk than older fathers of having children who will develop AD late in life. In contrast, these investigators found that the risk of having children who will eventually develop AD rises only slightly with increasing maternal age. Other studies, however, have not found correlations between either maternal or paternal age and AD risk in their children.

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES (NIAID)

NIAID research related to AD aims to understand and control viral diseases in the brain. Certain viral diseases of the brain share striking similarities to AD. Investigations are under way to identify common pathways by which these diseases may occur.

Scrapie viral infection causes a brain disease with amyloid fibrils similar to those found in Alzheimer-diseased brains. NIAID scientists, with NINDS-supported investigators, have found a role for astrocytes, a type of brain cell, in the development of amyloids in both diseases. The research team detected in both scrapie and Alzheimer-infected tissue an increase in nucleic acids that direct production of cathepsin D (CD), an enzyme found in abundance in AD. Because CD-positive cells were found near early plaques, the investigators suspect CD-producing astrocytes are responsible for amyloid formation.

Herpes simplex virus (HSV), a large DNA virus that remains latent in nerve cells, have been proposed as a means to deliver therapeutic genes to nerve cells. NIAID grantees have genetically engineered a herpes virus that can neither replicate nor cause reactivated infection. Using a mouse model, they have demonstrated that a "test" gene carried by the HSV mutant can be expressed in peripheral nerve cell. Such gene therapy may hold promise for AD and other neurodegenerative diseases as their genetic basis becomes known.

NATIONAL INSTITUTE ON DEAFNESS AND OTHER COMMUNICATION DISORDERS (NIDCD)

The NIDCD conducts and supports research on hearing, balance, smell, taste, voice, speech, and language. The NIDCD is the focal point for research on the causes and prevention of communication disorders associated with AD.

Dr. Elizabeth Bates, an NIDCD grantee at the University of California at San Diego, is studying the language disabilities of people with AD, specifically what types of language function are most affected by AD. She has found that AD patients have a reduced ability to form passive sentences (for example, "the man was hit by the car") and other complex grammatical structures. This finding has led to a better understanding of how AD affects language production.

NIDCD-Supported investigators studying the sense of smell have found indications that some forms of AD may be caused by toxins that enter the brain through the olfactory system. Scientists, therefore, may be able to develop drug therapy using this olfactory pathway to bypass the blood-brain barrier. This barrier helps isolate the brain from toxic agents but also prevents the entrance of therapeutic drugs. NIDCD grantees will continue to investigate the role of the olfactory nerve in the transport of toxins, pathogens, and drugs to the brain.

NATIONAL CENTER FOR RESEARCH RESOURCES (NCRR)

Resource centers and other resources provided by NCRR support a variety of studies focused on understanding and treating AD.

Researchers at the San Diego Microscopy and Imaging Resource funded by NCRR's Biomedical Research Technology program, using a confocal microscope to allow three-dimensional imagery and an electron microscope, found that AD reduces the number of synaptic connections between neurons in the brain by 40 percent. This reduction impairs the capacity of the nerve cells to send and receive the electrochemical signals necessary for proper brain function. The remaining axon terminals appear enlarged and abnormal. The results of this study reinforce those found by Drs. Terry, Katzman, and colleagues reported on in the main body of this report, which emphasize the loss of synapses in the development of the dementia of AD.

Researchers at the San Diego Microscopy and Imaging Resource also discovered that the NFTs found in the brains of AD patients seem to push the cell's nucleus and Golgi apparatus (which adds sugar to proteins) to the cell's edge. They theorize

that these changes may alter the cell's ability to function properly and may cause it to produce abnormal proteins.

Researchers at Columbia University's General Clinical Research Center have found that the drug acetyl-L-carnitine improves the mental abilities of some patients with AD. Patients with the most severe dementia tended to improve their baseline cognitive test scores more dramatically than those who functioned at a higher level prior to the study.

NATIONAL CENTER FOR NURSING RESEARCH (NCNR)

NCNR-supported studies focus on developing strategies to improve care and quality of life for the AD patient and the caregiver in the home or at an institution.

Most AD patients cannot perform basic activities of daily life because of cognitive impairment. Yet studies of nursing home residents show that some remain functionally independent despite serious cognitive deficits.

The NCNR is funding a study to identify behavioral strategies that can promote AD residents ability to function independently. Focusing on the task of dressing, health professionals led by a nurse scientist, have found that certain interventions resulted in significant improvement in residents' ability to dress themselves. These interventions included laying out clothes for the patients in the order that they are put on, or demonstrating dressing so that the patients can imitate. The residents also had fewer episodes of aggressive behavior. This year the team is studying linkages between level of improvement with type of cognitive deficit to determine which residents will benefit most from the interventions. The team is also developing interventions for other daily life activities. Caregivers at home also may be able to use these interventions.

OUTLOOK

Tremendous progress has been made this year in unraveling some of the mysteries of AD. The identification of specific genetic mutations leading to familial AD and the development of animal models of AD promise to further our understanding of the abnormal mechanisms of brain cell functioning that are the hallmarks of AD.

Several exciting developments for the coming year will focus on the important areas of identification of risk factors for AD, treatment, and care of AD patients. The first is the initiation of a cross-cultural study comparing black Americans and Nigerians aged 65 and older. It is hoped that the comparison of these two populations may lead to the identifications of possible environmental, genetic, and toxic effects that may be risk factors in the development of AD. A second project is the initiation of a 30-center Alzheimer's Disease Cooperative Study Unit to expedite the testing of promising new drug treatments for AD. A further NIA initiative is planned to examine different strategies for reducing burdens of care for relatives who provide primary care for family members with AD.

UNDERSTANDING AGING

An important goal of aging research is to identify the underlying mechanisms which drive the aging process and to determine new methods of prevention and treatment for the diseases and disabilities most commonly associated with old age. The importance of this research will increase in the coming years as the segment of the population over the age of 65 grows. Today, this age group accounts for approximately 12 percent of our population. By the year 2025, it will reach 20 percent. Such a major demographic shift requires that our country make profound changes in its system of health care, its methods of educating and training medical and other types of caregivers, and in the ability to provide rewarding roles for the increasing numbers of people who remain vigorous longer. The fruits of aging research can dramatically reduce the major risk factors for conditions such as osteoporosis, hip fractures, and urinary incontinence, for which older persons require expensive long-term care.

In the past year, NIA-sponsored research has produced major breakthroughs in our understanding of Alzheimer's disease, breakthroughs that scientists hope may one day lead to a delayed onset of this disorder. If the onset of Alzheimer's disease could be delayed by just 5 years, its incidence could be cut in half and the cost savings could potentially exceed \$40 billion annually. Similarly, \$3.5 billion could be saved by reducing frailty and dependence in older people, and effecting a 6-year delay in the onset of osteoporotic hip fractures. In addition, the Institute has announced a study to determine what diseases and events influence the disabilities affecting 4 million American women age 65 and older.

The ultimate purpose of all aging research is to improve the quality of life in the later years. To do so, however, people of all ages must make changes in their lifestyle, diet, and personal health care practices. Studies conducted and supported by the NIA will help define these changes. Dissemination efforts such as the cancer education initiative launched this year with the National Cancer Institute will bring these efforts to the public.

Other NIH institutes with an interest in aging research are the National Cancer Institute (NCI); the National Heart, Lung, and Blood Institute (NHLBI); the National Institute of Dental Research (NIDR); the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK); the National Institute of Neurological Disorders and Stroke (NINDS); the National Institute of Allergy and Infectious Diseases (NIAID); the National Eye Institute (NEI); the National Institute of Environmental Health Sciences (NIEHS); the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS); the National Institute on Deafness and Other Communication Disorders (NIDCD); the National Center for Research Resources (NCCR); the National Center for Nursing Research (NCNR); and the Office of the Director (OD).

DRUG TREATMENT REDUCES DISEASE FOR PEOPLE WITH COMMON FORM OF HYPERTENSION

Isolated systolic hypertension (ISH) is the common form of high blood pressure in Americans over age 65. Currently, 3 to 4 million people have ISH, and the number will increase to about 8 million by the year 2025. ISH is a major risk factor for the development of stroke and cardiovascular disease. The Systolic Hypertension in the Elderly Program (SHEP), a nationwide, multi-center clinical trial of nearly 5,000 men and women, sponsored by NIA and the National Heart, Lung, and Blood Institute, demonstrated that drug treatment significantly reduces the incidence of stroke, heart, attack, and other problems related to cardiovascular disease due to ISH. It is the first trial to identify a treatment benefit for any form of hypertension in people age 80 and older.

ISH is a condition where systolic pressure, or the upper number in the blood pressure ratio (the pumping pressure of the heart as it pushes blood into the arteries) is elevated. The diastolic blood pressure, or lower number (the resting pressure of the heart between beats) is normal. It is the single greatest risk factor besides age for the development of cardiovascular disease in older people. People with ISH have a two to three-fold increased risk of heart disease and a three-fold increased risk of stroke. Older black women have twice the rate of ISH as white women and Black or white men.

Because of the supposed irreversible "stiffening" of blood vessels seen with advancing age, many physicians previously believed ISH would be difficult or impossible to treat. They were also afraid that older people were more prone to adverse effects from antihypertensive drug treatment than younger patients, and that the metabolic effects of diuretics would be more severe in older people. The SHEP program proved these concerns to be unfounded.

Participants in the SHEP study were given either a once-daily dose of the diuretic chlorthalidone or a placebo. The objective was to use the minimal amount of medication to maintain systolic blood pressure at or below 160. Drug dosage was doubled for participants failing to achieve the goal at monthly followup visits.

According to Dr. Evan Hadley of NIA, low doses of chlorthalidone reduced the incidence of fatal and nonfatal stroke by 36 percent. Coronary heart disease was reduced by 27 percent. Researchers note that the treatments are uncomplicated, inexpensive, and caused no serious side effects. In patients where the diuretic alone is not sufficient to control the condition, a beta adrenergic blocking drug such as atenolol may be added.

Treating ISH will likely result in fewer admissions to hospitals and nursing homes. SHEP participants who were treated had an 11 percent lower rate of hospital and nursing home admissions than those who were not treated. Nationwide, treating ISH in older people could potentially prevent up to 84,000 hospital and nursing home admissions a year. Researchers estimate that as much as \$500 million could be saved each year if everyone with ISH were treated.

RESEARCHERS STUDY NON-DRUG INTERVENTIONS FOR URINARY INCONTINENCE

An estimated 10 million Americans, including 15 to 30 percent of all community-dwelling people, are affected by the loss of bladder control or urinary incontinence. In nursing homes, half of the residents suffer from urinary incontinence. The costs of managing the condition are estimated to be \$10.3 billion a year. Recent research conducted by NIA grantees has focused on treatment of the condition as well as on

the cost effectiveness of treating incontinence in residents of long-term care facilities who are severely mobility-impaired.

NIA grantees Dr. J. Andrew Fantal and his colleagues at the Medical College of Virginia in Richmond, have found that a 6-week program of bladder training can be an effective treatment for many women with urinary incontinence. Incontinence is twice as prevalent in women as men. The researchers conducted a controlled clinical trial of 123 community-dwelling women, 55 years of age and older, with stress or urge incontinence. Twelve percent of the women in the study became continent, while 75 percent of the women improved 50 percent or more.

Based on principles of behavior modification, the bladder training program consists of patient education and scheduled urination. Patient education includes an audiovisual program emphasizing the neurologic control of lower urinary tract function, and verbal and written instructions on how to adapt the program to one's lifestyle. Patients began a regular voiding schedule and kept daily treatment logs that were evaluated at weekly visits to the clinic. Those patients who had fewer incontinent episodes and who were able to keep to their schedules increased the interval between voidings by 30 minutes each week. The goal of the program was to reach 2- to 3-hour intervals between voidings.

Dr. Frantl's work included women with detrusor and sphincteric dysfunction. He recommends that "bladder training should be considered as an initial step before proceeding further [with drug or surgical therapy]."

Other NIA grantees, led by Dr. Thelma Wells of the University of Rochester in New York, compared the effectiveness of pelvic muscle exercise (PME), also known as Kegel exercise, to drug treatment for stress incontinence, the most common cause of urinary incontinence reported by community-dwelling older women. They concluded that among the women who completed the clinical trial, pelvic exercises helped reduce stress incontinence as well as treatment with the drug phenylpropanolamine hydrochloride (PPA).

Dr. Wells' clinical trial involved 118 community-dwelling women. Fifty-four women completed the treatment phase of the exercise protocol, while 64 women completed the treatment phase of the drug intervention. The drug used, PPA, is most often the drug of choice for urinary incontinence.

According to Dr. Wells, the participants responded successfully to PME after 5 months as long as they completed at least 80 exercises daily. When the participants were asked to note their own improvement, 77 percent of the PME group reported improvement, while 23 percent of the group reported no change. At the same time, 84 percent of the drug-treated group reported improvement, while 16 percent reported no change. However, according to the participants' diaries, 27 percent of the PME subjects became dry, 21 percent reported some improvement, and 21 percent reported no change. Twenty-seven percent reported an increase in wetting after treatment. Of the PPA participants, 14 percent became dry, 39 percent reported some improvement, and 19 percent reported no change. Twenty-nine percent noted an increase in wetting after treatment.

This study's demonstration that a non-drug treatment produced benefits at least as good as drug therapy is especially important because many older people take multiple medications. Often these medications interact to produce adverse effects. Finding a non-drug alternative treatment can allow older people to decrease their total number of medications and the risk of adverse drug effects.

NIA intramural scientists Drs. Kathleen A. McCormick and Bernard T. Engel and their colleagues studied the cost effectiveness of treating incontinence in long-term care residents with severely impaired mobility. Such patients usually are incontinent. Their immobility and incontinence predispose them to decubitus ulcers and urinary tract infections (UTI), conditions that add to the "consequence costs of incontinence" of \$80 million a year.

In this study of 10 female participants, staff used a pneumatic lifting device every 2 hours to help participants use a commode or bedpan. The researchers note that the participants' continence improved and their frequency of decubitus ulcers and UTIs decreased. They also note that because this treatment was labor intensive, it increased the cost of treating incontinence by \$2.90 over the cost of providing incontinent care. However, they suggest that when the costs of decubitus ulcers and UTIs are considered, the treatment savings amounted to \$13.38 per patient each day.

NEW MODELS DEVELOPED TO STUDY PROSTATE CANCER

More than 100,000 cases of prostate cancer are diagnosed annually, making it the most common cancer among American men. It is the second leading cause of male cancer deaths in the United States, claiming 30,000 lives each year. While researchers know that the incidence of all cancers increase with age, it is particularly true

of prostate cancer. More than 80 percent of all cases are diagnosed in men over age 65.

If detected early enough, while malignant cells are still contained in the prostate gland, prostate cancer is easily treatable with surgery. However, once cancer cells migrate to other areas of the body, it can be disabling and extremely difficult to treat successfully. NIA scientists are studying the complex series of events that enable malignant prostate cells to invade other tissues, glands, nerves, and muscles. Each step appears to be critical and represents a potential target at which to direct new therapeutic drugs.

In experiments on cells in culture and in mice, NIA intramural scientists Drs. Antonino Passaniti, Scott Adler, and George Martin, have found that a benign tumor cell is unable to detach itself from the primary tumor and migrate to another site. A malignant cell, however, frees itself from the connective tissues in which it is anchored by eating through the tissue's outermost portion, called the basement membrane. Malignant cancer cells are somehow triggered to release enzymes that erode the proteins of the basement membrane leaving holes through which the cells can pass into the lymphatic system or blood stream and disseminate throughout the body.

Preliminary studies indicate that malignant prostate cancer cells produce large amounts of collagenase IV, an enzyme that destroys the collagen in the basement membrane, and that inhibitors of this enzyme block cancer cell invasion. Furthermore, the injection with a mixture containing the basement membrane proteins into prostate tumor cells in mice resulted in increased tumor growth. The mice model may be useful in developing a broader range of human prostate tumors for study as well as a reproducible animal model for testing novel therapeutic agents to prevent cancer growth and spread.

CALORIC RESTRICTION PREVENTS DISEASE IN RODENTS

As part of the largest and most highly controlled animal study ever conducted on caloric restriction, scientists from Tufts University have determined that reducing caloric intake retards disease and extends life by one-third in rats and mice. Further, the calorically restricted animals showed a remarkable reduction in the incidence of most diseases and all types of tumors. The study gives even greater force to the idea that caloric restriction, once its mechanisms are understood, will provide new ways to eliminate or slow diseases associated with human aging.

In a large colony of mice and rats raised especially for aging research, scientists fed half the animals a diet consisting of 40 percent fewer calories than those on a typical feeding schedule. NIA grantee Dr. Roderick T. Bronson, Tufts University School of Veterinary Medicine and Medicine and his colleague Dr. Ruth Lipman, at USDA's Human Nutrition Research Center on Aging at Tufts University in Boston, MA, found in a sample of 1,100 test animals that for each sex and genotype studied, there were significantly fewer signs of disease (measured by number of lesions) and cancerous tumors in mice whose calories were restricted compared with those consuming a normal diet.

For example, at 24 months of age, only 13 percent of calorically restricted male and female mice had tumors, compared to a 51 percent tumor incidence in those without restricted diets. For females at 30 months, only 17 percent of the calorically restricted mice had tumors while all those on unlimited diets had tumors, and some had multiple tumors.

Dr. Bronson also found that the animals on restricted diets lived 29 percent longer. Half of all the animals on caloric restriction were still alive by the time all the animals on unrestricted diets were dead.

Dr. Bronson is cautious about applying these findings to humans yet. The mechanisms which influence disease and aging still need to be identified before the apparent benefits of caloric restriction can be fully understood.

These study results are among the first from NIA's Biomarkers of Aging program. The 10-year effort, begun in 1987 in cooperation with the National Center for Toxicologic Research, is designed to identify the changes, or biological markers, that occur with age and help define the concept of biological aging. The animal models show that advanced chronological age is not necessarily synonymous with ill health. Biomarkers, not years, are measures that more accurately reflect the biological state of an organism. If diseases such as cancer can be delayed or eliminated, health in advanced age can improve significantly. Investigators are considering a range of factors, from cellular DNA to physiological changes within the whole organism and behavior as possible biomarkers. NIA scientists hope to develop a series of biomarkers suitable to test interventions in human populations by the end of the decade.

SCIENTISTS SEARCH FOR AGING GENES

One of NIA's foremost initiatives is to uncover the mechanisms by which genetics and the environment help determine human longevity. Scientists know that the life span of a species is genetically determined. Yet within each species there is great diversity during aging. Researchers presume this is because certain genes common to all people are translated differently in each individual, causing some to remain healthier and live longer than others. Scientists are trying to determine which genes play a role in the process of aging.

Most likely, these "aging" genes instruct specific enzymes to help protect cells from DNA damage, control metabolism, maintain cell proliferation, or in some other way prevent the onset of age-related changes. NIA-supported researchers are attempting to identify these genes using lower organisms such as insects and roundworms as models. These organisms are easy to study because their environments can be rigidly controlled, their genetic makeup is well-known, and their genes are easily manipulated.

NIA grantee Dr. Thomas Johnson and his colleagues at the University of Colorado in Boulder, have found that altering a gene called *age-1* increases maximum life span by 110 percent in a roundworm model. However, they do not yet have a clear picture of the normal function of this gene. There is also evidence of a gene in yeast cells that for unknown reasons, allows old cells to survive. Scientists hope to learn the process by which these genes work to help explain why in humans an individual's chance of dying increases exponentially for every decade of life. With known human equivalents to the special "aging" genes found in lower animals, interventions could be developed that would prevent or reverse age-related changes. So far, only genetic manipulation and caloric restriction have been shown to increase maximum life span in any organism.

COGNITIVE TRAINING IMPROVES INTELLECTUAL ABILITIES OF OLDER PEOPLE

Researchers in the Adult Development and Enrichment Project (ADEPT) have observed an increase in cognitive ability after training older people. Previous studies show that age-related cognitive decline, particularly the ability to respond to new challenges and learn new skills, usually begins in the mid to late sixties. However, there are large individual differences in the rate of decline, with some adults beginning to show only mild signs in their late seventies. The ADEPT study conducted by NIA grantee Dr. Sherry Willis and her colleagues at Pennsylvania State University in University Park, determined the long-term effects of special cognitive training as participants advanced into old-old age.

While previous studies showed improvement in cognitive performance immediately after a short training session, participants were rarely able to retain training effects for more than a month. The ADEPT program looked at the impact of three phases of training over a period of 7 years. The 37 participants were healthy individuals in their late sixties living independently in the community. They were trained once in 1979 in their late sixties, again in 1981 in their seventies, and for the third time in 1986 in their late seventies. Phase I and II of the instruction consisted of five 1-hour sessions, and phase III of just two 1-hour sessions, due to participants' vision problems.

The training focused on the participant's ability to identify changing rules or patterns (such as size, shape, or position) in figures. The tests had four subtests, each involving a different type of figure. In the sessions, the trainer demonstrated the proper use of rules to solve the tasks. Then participants practiced individually and offered feedback on the correct solutions in a group discussion. Improvement in recognition, memory, and other intellectual skills relates to a significant range of practical, everyday tasks.

Results show that the greatest gains in intellectual ability were made in the first phase of training, while subsequent improvement was achieved more slowly. The study demonstrated that even older people starting at a low, or cognitively disadvantaged level, profited most from the early training session. However, everyone achieved higher scores on the tests at later phases because the training effects were cumulative.

All the participants were given baseline tests before the first training session to compare with the post-training tests. Surprisingly, as a result of the training, many of the older individuals performed better than they had in their baseline test when they were 7 years younger. This lends further evidence to the notion that cognitive processes remain adaptable so that even adults in their late seventies can significantly improve perceptual thinking and problem-solving. Overall, 64 percent of the

experimental group performed consistently above baseline, compared with only 33 percent of the group who received no training.

This research demonstrates that cognitive ability can be enhanced and retained through brief, periodic education classes. Researchers believe this improvement would diminish if older persons returned to a nonstimulating environment or did not continuously use the skills learned in training. The fact that aspects of intelligence can be improved relatively easily carries broad implications for older adults' independent functioning and productivity. The challenge for the future is to develop natural, daily activities that will continuously improve and maintain cognitive functioning.

INTERVENTIONS MAY REDUCE RISK OF DRIVING ACCIDENTS FOR OLDER PEOPLE

Older people are relying on driving more and more as their major means of transportation. While the majority of people over age 65 drive safely, older drivers generally have more crashes and fatalities per mile driven than any other adult age group. Most of these accidents occur at intersections and rights-of-way or during lane changes, suggesting that older drivers' accidents may involve paying attention to two or more separate sources of information, usually under some time pressure.

Recent research supported by the NIA has identified a test called "useful field of view" (UFOV) that measures the spatial area in which an individual can rapidly take in information from two separate sources. The UFOV test of visual attention is a strong predictor of accidents in older drivers, according to studies conducted by NIA grantee Dr. Karlene Ball of Western Kentucky University in Bowling Green and her colleagues at the University of Alabama at Birmingham. Dr. Ball has also found that a driver's UFOV can be expanded through several short training sessions. Dr. Ball's research suggests that policies restricting driving privileges based on age or on simple vision tests may not be appropriate.

Instead, the research team found, performance-based measures were the most effective predictor. In one study, 53 drivers, age 57 to 83, were tested for cognitive status, visual sensory function, UFOV, and eye health and were asked to fill out a questionnaire on their driving habits. Actual driving records were obtained from the state government.

Test results in each of the five areas were compared with crash records for the previous 5 years. The UFOV had the strongest correlation with crash frequency. Older drivers who failed a screening version of the field of view task had 4.2 times more accidents in general than those who passed. They averaged 15.6 times more intersection accidents. Poor useful field of view was a particular problem for older adults found at fault in crashes.

Dr. Ball and her colleagues have also found that training can expand the useful field of view. Through computer-controlled displays on a large screen, individuals in the study were subjected to a series of images. Sometimes, additional images appeared on the screen as distracters. With practice using these images, visual processing speed was increased, resulting in a wider field of view. In some cases, this expansion lasted for at least 1 year. While the scientists continue their work in the area, this research suggests that a simple intervention can substantially improve safety for older drivers.

DIABETES AND AGING

The NIA conducts and supports research on the physiological mechanisms of diabetes mellitus, a frequently occurring disorder associated with old age. Older people are often less active and gain weight. The increase in body fat associated with this weight gain then interferes with insulin action and may contribute to diabetes.

Recent NIA-sponsored research measured the effect of regular participation in physical exercise on the metabolic rate of sedentary and physically active younger and older men. The resting metabolic rate and the rate of calorie "burn-off" in a meal are factors which affect body composition. If calorie intake remains the same, higher resting metabolic rate and higher metabolic rate after meals help prevent an accumulation of body fat.

The study indicated that active older men burned calories more quickly after a meal and had a higher fasting metabolic rate than sedentary men. Physical activity helped maintain weight by increasing calories burned even at rest.

The results suggest that physical activity helps slow age-associated gains in body fat and may prevent or delay the onset of diabetes—a beneficial impact of regular exercise on a chronic disease of older people.

ARTHRITIS AND AGING

Arthritis is an area of special importance to the Institute since it is the most prevalent chronic condition in people over age 55. According to the National Center for Health Statistics, older women cite arthritis as the principal cause of limitation in activities, while older men rank it as second, after heart disease. Not surprisingly, musculoskeletal systems—such as pain, stiffness, and aching—top the list of health complaints for older adults.

A recent NIA study compared people with arthritis (i.e., osteoarthritis, rheumatoid arthritis, spinal and other rare forms) to those without the disease but who suffer from other chronic conditions. The study found that people with arthritis have more difficulty with physical functions, personal care, and household care than people without arthritis. Moreover, excess disability is greatest for physical functions (e.g., walking, reaching, stooping) compared with social activities (e.g., shopping, light housework). People with arthritis who are disabled have an especially high degree of difficulty in physical activities that require endurance and strength. The weak association between physical disability and social disability is believed to result from the successful adaptations made by people with arthritis who are able to prevent the disease from seriously affecting their daily lives. For people with arthritis, physical difficulties escalate especially when there are other concurrent chronic conditions.

Future research will continue developing the results of this study, which expand the scope of arthritis studies done in past years. For example, researchers will focus more on a variety of physical and social outcomes, rather than simply on standard indicators such as activities of daily living (ADL) and labor force participation; they will study community-based populations as well as arthritis patients and they will increase the emphasis on osteoarthritis which affects almost everyone after age 65.

Research on biomedical aspects of arthritis is also supported by NIA. For example, scientists have been examining the fluids in joints (synovial fluids) from patients with rheumatoid and other forms of arthritis. Specifically they have been examining the relationship between the immune responses in joint fluids and growth factors, such as transforming growth factor- β (TGF- β), which is now known as the most potent inhibitor of white blood cell (lymphocyte) function. Current results indicate that the presence of this specific growth factor TGF- β accounts for the ability of the joint fluids to suppress immune response, and that this may be responsible for functional and clinically observable changes in the white blood cells of joint fluids.

OLDER RURAL POPULATIONS

Access to medical and social services, a pressing problem for older people living in rural areas, was recently studied by NIA grantees. The researchers, studying a three-county area in New York, found that accessibility of day activity programs, congregate meal programs, and home-delivered meals varies greatly, depending on location. Rural areas are less well served than cities where a larger and more concentrated constituency for senior services often exists. For both day activities and home-delivered meals, it is more common for rural areas to either have no service or have less frequent service than urban areas. Residents of rural areas are more likely than other persons to occasionally participate in senior centers; however, they cannot participate as frequently because of the problems of accessibility.

To promote the health and effective functioning of all older people, the NIA is increasing its research on older people living in rural areas. In 1991, centers for research on older rural populations were established at the University of Florida, the University of North Carolina, Pennsylvania State University, and the University of Iowa. In addition, applications are now being accepted for studies of the "Health and Effective Functioning of Older Rural Populations" which examine the social, economic, psychological, environmental, and biomedical factors affecting older people in rural areas.

OLDER MINORITY POPULATIONS

The NIA is especially interested in research to improve the health and longevity of minority populations, particularly the environmental influences, family structure, social networks, and problems associated with life transitions as they relate to African-American, Asian, Hispanic, and Native American minorities.

Although valid and reliable data on morbidity and disability are not readily available, some studies suggest that minority older people suffer limitations and illness at earlier ages than the overall populations. Better understanding of racial and

ethnic differences in needs of older persons for health care is required in order to provide appropriate services for all Americans.

Researchers at Texas A&M University compared patterns of health care utilization among six populations of non-Hispanic white, Puerto Rican, Mexican, Cuban, and African-Americans. Pooled data from the 1976-84 National Health Interview Surveys allowed sufficient samples of 1,000 individuals in each ethnic group for analysis. Basic access to care was measured by whether any physician or hospital contact had been made within 1 year. Need, as a proxy for poor health or disability, was measured by the number of health care visits. With some variation among groups, minority older people visited the doctor more often than their age-matched nonminority counterparts. Researchers found that the demand for health services among younger African-Americans, Mexicans, and Puerto Ricans is equivalent to the demand among whites 65-69 years old. This supports the hypothesis that minority individuals reach "old age" about 5 years earlier than on-minorities.

Studies of minority aging find diversity among ethnic and racial groups, complicating research design and analysis. Data collection in the future may need to specify and oversample identified minority populations. Researchers using large, national data sets may pay greater attention to analyses of racial and ethnic subgroups and to a wider age range. Findings on minority differences in aging are critical for planning health services.

AIDS AND OLDER AMERICANS

AIDS is often considered a disease of the young, yet it has also affected a significant number of older adults. At the beginning of 1990, almost one-third of the 115,000 AIDS deaths in the United States involved people over age 40.

While the clinical presentation of AIDS is similar in both young and old people, studies examining the development of the disease have shown that older people infected with HIV-1 (human immunodeficiency virus type 1) experience a more rapid development of severe immune dysfunction than younger people. NIA investigators have been comparing the immune function changes that accompany HIV-1 infection in young people (ages 20-30) and old people (ages 58-76), which include groups of infected and non-infected adults the same age. The investigators found that the older participants had a lower percentage of peripheral blood T cells. An additive effect was created when the HIV-1 infection was combined with the loss of functional T lymphocytes that accompanies normal aging.

As HIV-1 infection in the older population is gradually better understood, physicians and policymakers can make informed decisions, for example, in choosing the appropriate therapy for opportunistic infections that occur during the end of the disease and have a particularly severe effect on the older population.

OLDER WOMEN'S HEALTH

Women account for about 59 percent of the United States population age 65 and above, and more than 72 percent of the population 85 and above. Given the predominance of women in the older age group, NIA has a special interest in supporting research on the health and well-being of older women. The Institute is particularly interested in research that identifies predictors of frailty or disability experienced by women in later life.

SPECIAL HEALTH PROBLEMS

Certain chronic diseases and conditions—such as arthritis, osteoporosis, and incontinence—disproportionately affect women. There are also many unanswered questions surrounding normal aging processes such as menopause. For example, what happens at the molecular level in bone cells when estrogen levels decrease following menopause?

Many diseases and conditions affect both aging men and women (e.g., Alzheimer's disease, cardiovascular disease, and frailty) but they have a special importance for women because of the high proportion of women in the older population.

ONGOING NIA-SUPPORTED RESEARCH

Current NIA research on issues specifically relating to women's health includes studies on hormonal changes that occur with age, osteoporosis, hip fractures, physical frailty, and incontinence. Additionally, the institute supports social and behavioral research specific to women, such as the role of older women as both recipients and givers of health care. The Institute also supports intramural and extramural longitudinal studies to collect data on the health of older women and men.

Two major ongoing NIA studies involve research on osteoporosis and on disability. In a program called STOP/IT (Sites Testing Osteoporosis Prevention/Intervention Treatments) the Institute is supporting clinical trials at five locations across the United States to test promising ways to prevent and treat osteoporosis in older people. The Women's Aging Study is another major 7-year investigation now being conducted at The Johns Hopkins University School of Medicine to determine what diseases or other events cause or influence disability in women over age 65.

The NIA's Baltimore Longitudinal Study of Aging (BLSA) has been collecting data on female volunteers since 1978 and on men since 1958, and women now account for almost half of the study participants. BLSA participants are studied intensively for physiological and behavioral changes to identify patterns of age changes, the mechanisms underlying these changes, and disease/aging interactions. Although there are similarities in aging between men and women, many differences have been found. For example, investigations confirm that gender differences are apparent in the higher prevalence of osteoporosis and urinary stress incontinence among women, as well as a later onset of ischemic heart disease. Detailed information about BLSA's female population is already becoming available through reports in a large number of publications. In early 1991 the Institute produced the report, *Research on Older Women: Highlights from the Baltimore Longitudinal Study of Aging*.

RESEARCH OPPORTUNITIES

Many valuable research opportunities exist that can offer findings which will greatly benefit large numbers of people. For example, we need research on disease prevention. One area of inquiry concerns why older women engage in fewer preventive activities than younger women. We know that older women—who have the highest rate of breast cancer—are far less likely than younger women to engage in breast self-examinations or to go for regular mammograms, but we don't know why. In addition to these lines of inquiry, we also need more studies on specific diseases such as the cancers that affect predominately older women (i.e., breast and gynecological cancers). Another promising area for research involves studies of older individuals who have successfully survived cancer.

Older women suffer disproportionately from frailty and accompanying disability. With advancing age, many find themselves having increased difficulty performing normal physical activities of daily living. Moreover, physical frailty in older people is responsible for a large share of the need for long-term care. Frailty is caused by disease, psychosocial factors, or by a combination of both. A better understanding of this mix is fundamental in order to develop strategies that can alleviate or modify disability.

Finally, the patterns of work and retirement among older women differ dramatically from those of older men, and these differences appear to be growing. While female participation in the labor force was low at the turn of the century, the number of women workers has rapidly climbed over the last several decades. At the same time, women as a group earn lower wages than men, often from the same job. In the 1990's work and retirement patterns of women are only now emerging. For example, data show a decline in older men in the work force, while there is no parallel decline in older women. These patterns point to the need for increased and targeted research in this area. The research is particularly needed because the population of older women will have an enormous impact on future health policy decisions, including policies affecting Medicare, Medicaid, and other federal programs directed toward the older population.

RESEARCH ADVANCES ON AGING SUPPORTED AND CONDUCTED BY OTHER NIH INSTITUTES

NATIONAL CANCER INSTITUTE (NCI)

Americans over 65 years of age have more than 10 times the risk of developing cancer as those under age 65. The NCI is using the full range of its resources to address this important problem, including information and awareness campaigns and studies of the changes that occur within the aging process.

An NCI educational initiative undertaken with the NIA is providing the latest information about cancer to older people, both to increase their use of early detection tests and to optimize their treatment choices. Messages about cancer are being delivered through print media, radio, television, and organizations for older Americans.

Research on the changes that happen in the body with aging and how these changes affect the risk for and effects of cancer are also underway. For example,

NCI-funded research showed that overweight post-menopausal women have different levels of sex hormones depending on where they carry extra body weight (around their abdomen or their hips). Obesity and hormone levels are known to affect the risk for endometrial and breast cancer.

NCI-funded researchers are also finding better ways to study damage to DNA that may play a role in aging and cancer. A test that can detect oxidative (degenerative) damage that has occurred to DNA in laboratory mice and rats has been developed. The test is an important tool for the extension of the studies to humans.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE (NHLBI)

The NHLBI supports research on aging related to the diseases of the heart, blood vessels, lungs, and blood. Findings from an NHLBI-sponsored clinical trial, Studies of Left Ventricular dysfunction (SOLVD), have demonstrated the benefits of a new treatment for chronic congestive heart failure. Chronic heart failure affects between 2 and 3 million Americans and is the leading cause of hospitalization among persons over 65 years of age. Further, its prevalence is increasing in large part because of improved survival from heart attack and a growing older population. The SOLVD trial assessed the benefits of intervention with an angiotensin-converting-enzyme inhibitor, enalapril, in patients with overt congestive failure. Use of that drug was associated with a 16 percent reduction in overall deaths and a 26 percent reduction in deaths or hospitalizations for heart failure. Implementation of the findings from this study is expected to save both lives and medical care costs for patients with symptomatic heart failure.

NATIONAL INSTITUTE OF DENTAL RESEARCH (NIDR)

The NIDR gives high priority to the oral health of older Americans. Intramural scientists reported this year that salivary gland output did not change with age in healthy persons followed over a 10-year period. This finding, corroborating other studies salivary function over the human life span, disproves the widely held belief that dry mouth and salivary gland dysfunction in older persons are a normal part of the aging process.

Grantees at an NIDR-supported center on oral health in aging reported only very modest changes with age in the ability to discern differences in certain taste sensations, facial temperature (warm/cool), and pain. Consistent with other studies, the scientists reported that the most pronounced change with age was reduced sense of smell. There were no significant differences in any of these sensations between men and women. A project assessing the periodontal status of persons age 65-74 showed that the nature of periodontal disease among older persons is the same as in younger age groups and does not correlate with the changes observed in immune function among some older persons.

Five contracts focusing on epidemiologic and intervention studies of oral health in high-risk populations were awarded this year as part of the NIDR Research and Action Program to Improve the Oral Health Americans and Other Adults at High Risk.

NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES (NIDDK)

More than 50 percent of men over age 40 and as many as 90 percent of men in their seventies and eighties have some symptoms of prostate enlargement, or benign prostatic hyperplasia (BPH). Although prostate growth during puberty is normal, in the older male it can obstruct the flow of urine, resulting in urinary infection, frequency, urgency, and retention. Nearly 80 percent of operations for BPH are in men age 65 and older.

The NIDDK supports research on the causes and treatments of BPH. One recent NIDDK-supported study on the disorder has found that while prostate growth in man is dependent on testosterone and dihydrotestosterone (DHT), prostate tissue can be grown in the laboratory without these hormones. This finding by the George M. O'Brien Urology Research Center at Northwestern University Medical School in Chicago, suggests that other factors may influence prostate growth in man. Further studies by these investigators will attempt to identify and understand these factors.

The NIDDK recently developed a 5-year plan to encourage basic and clinical research on prostate diseases. The plan calls for a clinical trial to study BPH and a database to provide information on incidence, prevalence, racial distribution, predisposing conditions, interrelationships, and long-term consequences of prostate diseases.

NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE (NINDS)

The NINDS conducts research on a number of nervous system disorders—such as stroke, Alzheimer's disease, and Parkinson's disease—that occur with greater frequency in older people.

PARKINSON'S DISEASE

Parkinson's disease, characterized by tremors, rigidity, and difficulty initiating movement, adversely affects the quality of life for more than half a million people in the United States. Even simple tasks, such as holding a spoon or getting out of a chair, can become impossible for Parkinson's patients. Symptoms of the disease occur because of the loss of brain cells that produce dopamine, a chemical in the brain. While many advances have been made in treating the symptoms of Parkinson's disease, the underlying cause remains a mystery. This year, significant findings by NINDS investigators are yielding intriguing new clues to the disease.

NINDS-supported scientists have discovered that Parkinson's patients have a curious defect in their cells' energy-producing components, known as mitochondria. Studies have shown that the activity level of patients' mitochondria is greatly reduced compared to healthy persons. This deficiency was traced specifically to the mitochondrial enzymes, which act as catalysts in converting food into the vital energy needed for cellular activity. Such a deficit can result in reduced cellular energy production and possible cell death.

NINDS grantees have also discovered that normal dopamine metabolism in healthy dopamine-producing nerve cells may prompt the release of free radicals, unstable chemical fragments that can react with and damage other cells through a process called oxidation. While the dopamine-producing cells produce free radicals, they also produce substances that can protect healthy cells. Parkinson's disease may have self-accelerating properties in that progressive loss of dopamine-producing cells can lead to a loss of the capacity to resist the harmful effects of oxidation, known as oxidative stress.

Supporting these concepts is the observation that the neurotoxic chemical MPTP, which causes Parkinson's-like symptoms in animal models of the disease, appears to inhibit mitochondrial activity and cause oxidative stress.

This research suggests that Parkinson's disease may be caused by a biochemical defect, possibly resulting from the influence of environmental factors in genetically susceptible persons. As they further their basic understanding of the cause of Parkinson's disease, scientists also work to find new and improved therapies to halt its devastating course.

STROKE

Stroke, an interruption of blood flow to the brain, affects about 500,000 Americans each year, many of them over age 65. This year an NINDS-supported clinical trial showed that a type of surgery called carotid endarterectomy can cut the risk of stroke in certain patients by as much as two-thirds. In this procedure, surgeons remove the fatty deposits in the carotid arteries, which carry blood through the neck to the brain. The surgery—which has the most dramatic benefits in patients whose carotid arteries are narrowed by at least 70 percent and who have previously had a stroke or its symptoms—reduces their chances of having a stroke from greater than 1 in 4 to less than 1 in 10.

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES (NIAID)

As people age, their immune systems gradually become less able to fight off infection. The NIAID conducts and supports research on the immune system and on many of the viral and bacterial infections that can cause life-threatening illness in older people.

NIAID-supported investigators are studying certain white blood cells that produce chemicals responsible for initiating and orchestrating the immune response. Scientists have found that the relative proportions of some subsets of these cells change with age, and the changes could lead to diminished immune competence. Further studies need to be done to understand the role such changes play in the immune system decline that occurs with age.

Researchers supported by NIAID are also studying ways to bolster the immune system. Varicella-zoster virus (VZV), which causes chicken-pox, may reactivate later in life and cause herpes zoster, also known as shingles. Investigators have found an increase in certain cells of the immune system following natural virus reactivation (shingles) or VZV immunization that persists for at least 2 years. This finding sug-

gests that although the aging immune system is weakened, it is still able to mount a significant response to an infectious agent or vaccine.

NATIONAL EYE INSTITUTE (NEI)

Half of all visually-impaired Americans are age 65 or older. This older population accounts for one-third of all visits for medical eye care. A major goal of the NEI research is finding ways to reduce age-related vision loss and the decline in quality of life that often accompanies this loss.

As a person ages, yellow proteins appear in the lens of the eye. Although these proteins protect the retina from damaging solar rays, they also slow the release of radiation—a suspected risk for cataract development. An NEI grantee recently found that these yellow proteins retain radiation at least three times longer than proteins found in the lenses of young people. The investigator and other NIH-funded scientists are determining whether radioprotector compounds can slow the potential damage from the sun's rays.

To learn why long-term steroid treatment increases the risk for glaucoma, NEI-funded grantees have cloned the gene for the major steroid-induced protein found in eye tissue. To find possible ways to modulate the gene's activity, they are now characterizing the biochemical switches that turn on and off the gene activity.

In other research, an NEI-funded scientist recently identified two types of nerve cells that carry messages from the retina to the brain: M cells that relay motion in dim light and P cells that relay fine lines and color. Another NEI grantee tested humans for early M-cell loss. The researcher is now following potential glaucoma patients to see if M-cell loss predicts optic nerve loss. If it does, physicians could use the test to determine if or when glaucoma treatment should begin.

NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES (NIEHS)

The NIEHS conducts basic and applied research on the aging process, the effects of environmental agents on aging, and the effects of aging on the ability to combat exposure to environmental agents.

NIEHS-supported scientists are studying environmental agents to determine what role they might play in the development of diseases primarily affecting older people. One such study is investigating the potential role of phytoestrogens (naturally occurring estrogen-like compounds found in plants) on hormone levels and the development of osteoporosis in postmenopausal women. The value of phytoestrogens is still unclear; while one preliminary study has shown that diets rich in phytoestrogens may delay or inhibit osteoporosis, other studies have shown that these compounds increase the likelihood of certain types of cancer. The ongoing NIEHS epidemiology study will help to determine if a link exists between high dietary phytoestrogen intake and disease prevention or formation.

Other NIEHS-supported scientists are investigating the effects of heavy metals such as lead, mercury, cadmium, and aluminum on the aging brain. These studies are expected to determine if environmental contaminants found in fish, cigarette smoke, ground water, or the air, play a role in the development of neuro-degenerative diseases of the brain such as Alzheimer's disease.

NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES (NIAMS)

Many of the disease conditions under the aegis of the NIAMS are associated with aging. These include certain bone diseases such as osteoporosis and Paget's disease, joint diseases such as osteoarthritis, degenerative back diseases, and skin diseases such as pemphigus.

NIAMS support for osteoporosis research is yielding results in basic, clinical, and epidemiologic areas. For example, researchers at Thomas Jefferson University in Philadelphia recently found a defect in a gene for type 1 collagen in a patient who has osteoporosis. Future research may reveal whether the genetic defect occurs in other people and can be used to identify a population at risk for developing osteoporosis.

Among fractures related to osteoporosis, hip fracture is one of the most serious. More than 90 percent of such fractures occur in persons over 70 years of age. Ninety percent of hip fractures result from a fall. Researchers in Philadelphia and New York studied the causes of hip fractures from falls in 174 women (median age, 80 years). They identified several risk factors, including physical dysfunction and use of medicines that dull the senses. This research suggests that prevention of hip fractures should include measures to prevent falls, as well as those to prevent bone loss.

In a study of nearly 10,000 women over age 65, researchers in Pittsburgh, San Francisco, and Minneapolis found that probably fewer than one in six older women are on estrogen replacement therapy (ERT), the most widely approved therapy to prevent bone loss following menopause. These findings suggest the need to study barriers to use of ERT, as well as alternatives to ERT that afford effective protection against these diseases.

NATIONAL INSTITUTE ON DEAFNESS AND OTHER COMMUNICATION DISORDERS (NIDCD)

Presbycusis, the loss of hearing associated with the aging process, is the most common auditory disorder found in older Americans. The NIDCD is responsible for research on hearing, smell, taste, voice, speech, and language.

A team of NIDCD-supported investigators in Louisiana is conducting the long-term study entitled *Old Time Ears* in which a group of hearing scientists, age 65 and older, are participating in a study of the auditory system. Results thus far indicate that the aging process more often affects the structures of the outer, middle, and inner ears rather than the higher auditory processing centers in the brain. The participants demonstrated varying degrees of hearing loss.

Another common disorder among older people is aphasia, a language disorder that affects the ability to understand the written and spoken word. NIDCD-supported scientists have found that aphasia patients who have disturbances in recognizing and discriminating speech sounds may be quite capable of recognizing and understanding spoken words. Researchers have shown that naming ability continues to improve in severely aphasic patients more than any other skill. This funding supports other evidence that naming depends on a broadly distributed neural network which can spread to adjacent undamaged brain tissue.

NATIONAL CENTER FOR RESEARCH RESOURCES (NCRR)

Resource centers and other funding mechanisms provided by the NCRR support a variety of studies focused on understanding and treating aging-related diseases and disorders.

At the University of Wisconsin Regional Primate Research Center, scientists have found that the elastic tissue that connects the ciliary muscle in the eye to the posterior sclera (part of the eyeball) stiffens with age in the rhesus monkey and appears to cause farsightedness, a common age-related ailment. This contradicts classical theory which states that the ciliary muscle functions normally throughout life and that farsightedness is due to loss of elasticity of the lens. This discovery offers a new approach to the study and treatment of farsightedness.

Postmenopausal women commonly experience an age-related decrease in bone mass and an increase in bone fragility. A study conducted at the University of California-San Francisco General Clinical Research Center indicates that neutralizing endogenously produced noncarbonic acids with potassium bicarbonate, taken orally, can improve the balance of skeletal minerals, reduce the rates of resorption, and increase the rates of bone formation in postmenopausal women.

NATIONAL CENTER FOR NURSING RESEARCH

The National Center for Nursing Research (NCNR) focuses on long-term care strategies for older individuals to help them maintain optimal health status, the highest functional abilities, and the best quality of life possible.

One widespread impediment to long-term care is the presence of confusion in older people, which some studies indicate affects half of hospitalized older patients. This condition complicates treatment and increases the likelihood of falls, dehydration, and drug toxicity. The NCNR is funding studies of nursing models, assessment scales, and intervention strategies to determine the nature of confusion, at what point it occurs, and what nurses and others can do to prevent or modify it.

One preliminary study concerns the use of a statistical model to describe the causes, development, and modification of acute confusion. Another study involves a new evaluation scale that can be scored by nurses at bedside, is only minimally stressful to patients, and more sensitive to revealing early/mild cognitive disturbances than other mental status tests. The early identification of patients who may require intervention can help avoid the use of physical or chemical restraints. Nursing interventions for combating confusion are being evaluated this year by the research team to see if patients' functional capabilities have been improved and their hospital recidivism rates lowered. Results of these studies can improve the nursing staff's ability to modify the damaging effects of confusion.

Whether exploring the mysteries of biological aging or improving the effectiveness of nurses, NIH-funded research in the field of aging promises to enhance the quality of life for all Americans, both young and old. We are learning that the changes we make today can improve our odds of remaining healthy, active, and productive well into old age.

OUTLOOK

NIA's first 17 years have produced a comprehensive research effort designed to understand the nature of aging, as well as the health and social implications. In the short run, the research is making available practical, effective interventions for older people and their families. In the long run, this effort is concerned with the fundamental processes of aging and what the experience of old age can be in the lives of people when disease and disability is greatly reduced.

The research carried out by NIA has already begun to show us that degenerative changes that occur with advancing age can be modulated and sometimes prevented by a range of interventions. We have traveled a great distance beyond the notion that the quality of life must inevitably deteriorate, a belief commonly held throughout most of human history. The general picture of human aging is growing clearer: although there may be wide individual differences, aging processes can often be slowed down and the quality of life improved. With increased understanding, research advances are enabling us to make better, more rational choices, as well as helping to form a society prepared to enjoy the gift of a healthy and satisfying old age.

NATIONAL INSTITUTE ON AGING ACTIVE GRANTS IN FY91

Grant number	Principal investigator title	Budget start	Dates end	Institution	Total
5 T35AG00089-10	Fanagan, Thomas D., short-term research training	09-01-90	08-31-92	State University of New York at Buffalo	67,091
5 T32AG00120-05	Burton, John R., research training in gerontology and geriatrics	06-01-90	12-31-91	Johns Hopkins University	156,561
5 T32AG00124-05	Holt, Peter R., Digestive Disease and aging training program	09-01-90	06-30-92	St. Luke's Roosevelt Hospital Center (New York)	63,063
5 T32AG00129-05	Bumpass, Larry L., population, life course, and aging	07-01-90	09-08-91	University of Wisconsin Madison	138,247
5 T32AG00130-05	Kaysner-Jones, Virgene S., research training in gerontological nursing	09-01-90	09-30-91	University of San Francisco	36,683
5 T32AG00143-05	Orr, Harry T., behavioral genetics/biology of aging	09-01-90	08-31-92	University of Minnesota-St. Paul	51,866
5 T32AG00160-04	Greev, David S., institutional national research service award	09-30-90	06-30-92	Brown University	6,349
5 T32AG00161-04	Eaton, William W., psychiatric epidemiology training grant	07-01-90	12-31-91	Johns Hopkins University	53,125
5 K07AG00301-06	Kowal, Jerome, geriatric leadership academic award	08-01-90	12-31-91	Case Western Reserve University	86,400
5 K01AG00399-03	Dutta, Purabi, effects of age and riboflavin on B-adrenergic activities	02-01-90	01-31-92	Sloan-Kettering Institute for Cancer Research	67,392
5 K08AG00439-02	Earl, Nancy L., genetic epidemiology of late onset Alzheimer's disease	05-01-90	04-30-92	Duke University	63,785
5 P01AG00541-14	Weksler, Marc E., immunobiology of aging	05-03-90	04-30-92	Cornell University Medical Center	414,587
5 P01AG00599-14	Minaker, Kenneth L., program project in biomedical aspects of aging	07-01-90	12-31-91	Beth Israel Hospital (Boston)	235,355
5 R01AG01512-09	Lu, John K., hormone secretion and receptor patterns during aging	07-01-90	06-30-92	University of California Los Angeles	139,841
5 R01AG02802-09	Mayeux, Richard P., behavioral/biochemical correlates in diseases of aging	09-15-90	06-30-92	Columbia University New York	173,196
5 R01AG02832-09	Strohmman, Richard C., muscle maturation: growth factors and aging	12-01-89	11-30-91	University of California Berkeley	131,692
5 P01AG02921-09	Caplan, Arnold I., extracellular matrix and aging	08-01-90	11-30-91	Case Western Reserve University	807,011
5 R01AG03382-07	Ebersole, Jeffrey L., effect of aging on secretory (GA immune system	09-01-90	04-30-92	University of Texas Health Science Center San Antonio	130,973
5 R01AG03763-06	Whisler, Ronald L., cellular mechanisms of human immunosenescence	03-01-90	02-28-92	Ohio State University	132,327
5 R01AG04053-06	Kaufman, Sharon R., chronicity and life reorganization in old age	05-01-90	10-31-91	University of California San Francisco	129,431
5 P01AG04861-05	Levine, Elliot M., studies of human endothelial cells of diverse origin	12-01-89	11-30-91	Wistar Institute of Anatomy and Biology	763,046
5 R01AG04924-05	Zautra, Alex J., life events and demoralization in the elderly	09-01-90	06-30-92	Arizona State University	89,987
5 R01AG04970-03	Norman, Eric J., early urine B12 deficiency detection in elderly	04-01-90	03-31-92	University of Cincinnati	152,928
3 R01AG04980-28S2	Thorbecke, Geertruida J., lymphoid cells production of antibodies	04-01-88	02-28-92	New York University	40,066
5 R01AG05188-02	Barker, William H., mortality decline among the aged—explanatory factors	07-01-90	06-30-92	Kaiser Foundation Research Institute	198,601
7 U01AG05270-07	Schnelle, John F., behavior management of urinary incontinence	08-16-90	02-29-92	University of California Los Angeles	131,853
1 F32AG05512-01	Peterson, Daniel A., synaptic integration of grafts to senescent hippocampus	06-01-91	05-31-92	University of California San Diego	20,000
1 F32AG05518-01	Ng, Alexander V., aging: sympathetic-vasoconstrictor response to stress	10-01-90	09-30-91	University of Arizona	20,000
1 F32AG05533-01	Levison, Deborah, living arrangements of the elderly in Brazil	09-01-91	08-31-92	Yale University	20,000
1 F32AG05538-01	Hoptman, Matthew J., aging and regional cerebral function	01-22-91	01-21-92	University of Wisconsin Madison	20,000
1 F32AG05540-01	Korol, Donna L., neurophysiological mechanisms of forgetting in aging	01-01-91	12-31-91	University of Arizona	20,000

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Grant number	Principal investigator title	Budget start	Dates end	Institution	Total
1 F32AG05541-01.....	Koepke-Secundo, Evelyn M., biology of cerebral aging.....	10-03-90	10-02-91	New York State Office of Mental Health.....	21,000
1 F32AG05542-01.....	Hensel, Linda L., senescence mutant isolation in arabidopsis thaliana....	03-01-91	02-29-92	University of Wisconsin Madison.....	20,000
5 R29AG05591-05.....	Cuba, Lee J., place identities among elderly migrants and non-migrants.	08-01-90	07-31-92	Wellesley College.....	52,678
5 R29AG05592-06.....	Carstensen, Laura L., behavioral effects of aging in long-term care.....	12-01-89	11-30-91	Stanford University.....	103,757
5 R29AG05609-05.....	Brown, Scott C., aging and the interaction of demography and hearing loss.	05-01-90	09-30-91	Gallaudet University.....	82,237
5 R01AG05657-06.....	Pettegrew, Jay W., NMR studies of brain aging in alzheimer's disease..	08-01-90	07-31-92	University of Pittsburgh at Pittsburgh.....	139,105
5 R01AG05977-03.....	Rogol, Alan D., regulation of gonadotropin secretion in aging women....	09-30-90	07-31-92	University of Virginia Charlottesville.....	120,401
5 R29AG06017-05.....	Lakoski, Joan M., aging and estrogen on biogenic amine cell physiology.	12-01-89	11-30-91	University of Texas Medical Branch.....	95,760
5 R01AG06158-04.....	Scheuer, James, effect of exercise in preventing cardiac aging.....	03-01-90	02-29-92	Montefiore Medical Center (Bronx, NY).....	138,594
5 R29AG06182-05.....	Forster, Michael J., immunologic correlates of memory decline.....	07-01-90	06-30-92	Texas College of Osteopathic Medicine.....	82,655
5 P01AG06309-05.....	Maletta, Gabe J., clinical research center for management of dementia.	04-01-90	03-31-92	University of Minnesota at Minneapolis-St. Paul.....	305,900
5 R01AG06346-04.....	Rose, Michael R., genetically postponed senescence in drosophila.....	07-01-90	03-31-92	University of California Irvine.....	129,108
5 R01AG06350-05.....	Abraham, George N., immunologic analysis of premalignant and malignant B-cells.	08-01-90	07-31-92	University of Rochester.....	176,483
5 R01AG06352-05.....	Martin, Arlene P., membrane lipid-associated changes during aging.....	09-01-90	08-31-92	University of Missouri Columbia.....	95,646
5 R01AG06383-03.....	Wood, John G., Alzheimer and aging brain cytoskeletal phosphorylation.	04-01-90	03-31-92	Emory University.....	90,671
5 R01AG06384-04.....	Luine, Victoria N., hormonal influences on forebrain cholinergic systems.	12-01-89	11-30-91	Hunter College.....	107,510
5 R29AG06387-05.....	Stern, Steven N., job exit behavior of older workers.....	07-01-90	09-30-91	University of Virginia Charlottesville.....	84,382
5 R29AG06407-05.....	Komm, Barry S., role of estrogen in bone biology and osteoporosis.....	07-01-90	12-31-91	University of Arizona.....	83,841
5 R29AG06434-05.....	Gerhardt, Greg A., age-induced changes in monoamine presynaptic function.	08-01-90	07-31-92	University of Colorado Health Sciences Center.....	80,964
7 R01AG06442-06.....	Paige, Gary D., sensory-motor/adaptive mechanisms in equilibrium control.	09-01-90	08-31-92	University of Rochester.....	189,055
5 R44AG06511-03.....	Holmes, Douglas, computer-based intervention for demented elderly.....	01-01-90	12-31-91	DMH Associates, Inc.....	108,999
5 R01AG06591-04.....	Kitson, Gay C., violent death—life course adjustment for widows.....	07-01-90	06-30-92	University of Akron.....	236,773
5 R01AG06621-04.....	Schultz, Albert B., biomechanics of human falls in young adults.....	08-01-90	09-30-91	University of Michigan at Ann Arbor.....	180,998
5 R01AG06794-02.....	Czaja, Sara J., age differences in task stress for computer tasks.....	01-01-90	09-30-91	State University of New York at Buffalo.....	41,765
5 R01AG06831-03.....	Logan, John R., informal and formal supports in aging.....	05-01-90	12-31-91	State University of New York at Albany.....	135,919

5 R29AG06977-05	Rosenthal, Mark J., central regulation of glucocorticoides—effects of age.	09-01-90	08-31-92	University of California Los Angeles	67,393
5 R01AG07050-03	Rubinstein, Robert L., lifestyles and generativity of childless older women.	04-01-90	03-31-92	Philadelphia Geriatric Center-Friedman Hospital	153,137
5 R01AG07153-03	Belmont, John M., problem solving and memory in elderly adults	04-01-90	03-31-92	University of Kansas Medical Center	122,356
5 R01AG07224-05	Feinberg, Irwin, waking-sleep relationships in development and aging	09-01-90	08-31-92	University of California Davis	108,528
5 R01AG07226-03	Schmucker, Douglas L., aging impairment of gut mucosal immunity	07-01-90	12-31-91	University of California San Francisco	78,366
5 R01AG07230-02	Blau, David M., dynamics of retirement behavior of individuals	08-01-90	07-31-92	University of North Carolina Chapel Hill	57,923
5 R01AG07350-03	Tobis, Jerome S., experimental intervention for the reduction of falls	08-01-90	07-31-92	University of California Irvine	240,451
5 R01AG07369-03	Schirch, Verne G., protein deamidation; role in protein turnover and aging.	03-01-90	02-28-92	Virginia Commonwealth University	94,972
5 R01AG07438-04	Pestronk, Alan, aging and the neuronal cytoskeleton	08-01-90	07-31-92	Washington University	136,189
5 R01AG07462-03	Levine, Michael S., dopaminergic modulation of aging striatum	04-01-90	03-31-92	University of California Los Angeles	125,536
5 R01AG07470-03	Chau, Vincent, aberrant ubiquitinylation in aged and alzheimer brain	04-01-90	03-31-92	Wayne State University	126,651
5 R01AG07560-03	Barnes, David W., determinants of cellular senescence in vitro	05-01-90	04-30-92	Oregon State University	106,865
5 R01AG07591-03	Kozikowski, Alan P., agents for the treatment of memory and learning disorders.	04-01-90	11-30-91	University of Pittsburgh at Pittsburgh	129,219
5 R01AG07604-03	Hauser, Robert M., trends in SES achievement across the life course	05-31-90	05-31-92	University of Wisconsin Madison	179,605
5 R01AG07657-03	Sohal, Rajindar S., cellular aging and oxygen free radicals	08-01-90	01-31-92	Southern Methodist University	88,103
5 R01AG07790-03	Lachman, Margie E., enhancing memory control beliefs and performance.	08-01-90	07-31-92	Brandeis University	48,818
5 R01AG07798-03	Bartlett, James C., human aging and face memory	09-01-90	12-31-91	University of Texas Dallas	53,499
5 R01AG07802-03	Davis, Maradee A., epidemiology of osteoarthritis and disc degeneration.	08-01-90	07-31-92	University of California San Francisco	161,898
5 R01AG07866-03	Carroll, James P., postural system in the aged	08-01-90	07-31-92	Pennsylvania College of Optometry	107,036
5 R01AG07875-03	Bruce, Sarah A., cellular aging of mesenchyme tissue in vivo and in vitro.	07-01-90	06-30-92	Johns Hopkins University	182,572
5 R01AG07895-03	Zacks, James L., visual processing of features and objects in aging	08-01-90	07-31-92	Michigan State University	83,897
5 U01AG07929-03	Defriese, Gordon H., self-care assessment of the community-based elderly.	08-01-90	12-31-91	University of North Carolina Chapel Hill	181,100
5 R01AG07985-02	Gubrium, Jaber F., institutionalization and life course narrative in old age.	09-01-90	08-31-92	University of Florida	113,576
5 R01AG07997-03	Morokoff, Patricia J., age, psychosexual response, and reproductive hormones.	04-01-90	03-31-92	University of Rhode Island	52,781
5 R01AG08018-24	Aminoff, David, biosynthesis and degradation of blood group substances.	05-01-90	11-30-91	University of Michigan at Ann Arbor	106,153
5 R01AG08082-02	Willis, Sherry L., practical intelligence and mental abilities in old age	07-01-90	06-30-92	Pennsylvania State University-University Park	250,499
5 R01AG08145-03	Rice, Dorothy P., costs of formal and informal care alzheimer's patients.	07-01-90	12-31-91	University of California San Francisco	141,039
5 R01AG08189-03	Davanzo, Julie S., demographic changes and family decision making	07-01-90	06-30-92	Rand Corporation	38,817

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Grant number	Principal investigator title	Budget start	Dates end	Institution	Total
5 R01AG08191-03	Schulze, Dan H., characterization and expression of IG gene families	09-01-90	08-31-92	University of Maryland Baltimore Professional School	139,651
5 R01AG08192-03	Kelsoe, Garnett H., age's immunological consequences—analysis of clones.	08-01-90	07-31-92	University of Maryland Baltimore Professional School	124,667
5 R01AG08193-03	Cerny, Jan, auto-reactive-idiotypic lymphocyte.....	08-01-90	07-31-92	University of Maryland Baltimore Professional School	189,455
5 R01AG08235-02	Hultsch, David F., individual differences in memory change in the aged.	08-01-90	07-31-92	University of Victoria.....	48,803
1 R15AG08317-01A1	Davis, Hasker P., implicit memory in young middle-aged and elderly	08-01-90	07-31-93	University of Colorado at Colorado Springs.....	114,062
5 R01AG08330-03	Ellner, Jerrold J., immunosenescence and tuberculosis in the elderly	09-01-90	03-31-92	Case Western Reserve University	230,436
5 R01AG08436-02	Einstein, Gillies O., prospective memory across the adult lifespan.....	09-01-90	05-31-92	Furman University	66,526
5 R01AG08544-02	Sherwood, Sylvia, mental disorders among Delaware nursing home patients.	03-01-90	11-30-91	Hebrew Rehabilitation Center for Aged.....	129,245
5 R01AG08655-02	Kotlikoff, Laurence J., consumer behavior, transfers, and the extended family.	09-01-90	08-31-92	Boston University	92,792
5 R01AG08726-02	Hendrie, Hugh C., dementia screening methods.....	03-01-90	02-29-92	Indiana University-Purdue University at Indianapolis.....	199,776
1 R13AG08949-01	Iqbal, Khalid, international conference on Alzheimer's disease	05-03-90	10-31-91	New York State Clinic for Mental Hygiene Planning	30,106
1 R13AG08966-01	Rice, Dorothy, compression of morbidity—conference	03-01-90	02-29-92	Kaiser Foundation Research Institute	47,894
1 R15AG08978-01	Duffy, Lawrence K., aging and alzheimer amyloid protein chemistry	04-01-90	03-31-93	University of Alaska Fairbanks	103,820
1 R15AG09059-01	Oldridge, Neil B., aging and functional outcome after surgery for SDM.	04-01-90	03-31-93	University of Wisconsin Milwaukee.....	99,133
1 R15AG09130-01	Lima, Susan D., phonological recoding and adult aging.....	04-01-90	03-31-93	University of Wisconsin Milwaukee.....	83,121
Total.....					13,502,223

NATIONAL INSTITUTE OF MENTAL HEALTH—INTRODUCTION

The National Institute of Mental Health (NIMH) conducts and supports a wide range of research and related activities with direct and indirect relevance to issues of aging. This includes basic research in the neurosciences and behavioral sciences, clinical research in the geriatric mental disorders, and services research related to the utilization and financing of mental health care. Clinical and research training programs as well as service demonstration programs are also supported.

In fiscal year 1991 the NIMH budget for research, training and demonstrations directly concerned with aging was \$28,389,000. An additional \$15,884,000 was spent for basic research and research training related to issues of aging. Thus, total NIMH direct and related expenditures for aging in FY 1991 were \$44,273,000.

Expenditures were made in the following categories:

NIMH EXPENDITURES IN AGING, FISCAL YEAR 1991

	Direct	Related
Extramural Research	\$21,502,000	\$12,806,000
Intramural Research	6,000,000	
Research Training	677,000	2,051,000
Clinical Training	210,000	1,027,000
Total	28,389,000	15,884,000
Grand total		44,273,000

This report provides information on program developments in research, research training, and clinical training, and also provides information on developments in mental health services demonstrations for the elderly.

EXTRAMURAL PROGRAMS

CLINICAL RESEARCH

The Institute supports a broad spectrum of research projects in the area of clinical research. The core of the research program is to understand and address more effectively the causes, prevention, treatments, and rehabilitation of mental illness in the elderly. Special attention is paid to research in Alzheimer's Disease.

Clinical research in the geriatric mental disorders has developed into a coherent and sophisticated body of knowledge. Using the best of contemporary approaches in molecular genetics and neurobiology, investigators in Alzheimer's Disease continue to be involved in studies of chromosomal abnormalities on chromosome 21; neurobiological approaches to the development of diagnostic markers; imaging studies using PET, MRI, and electrophysiological mapping procedures; and neuropsychological studies. While the treatment of the core cognitive symptoms of Alzheimer's Disease remains elusive, there are some promising findings using a new cholinesterase inhibitor, as well as with approaches to treatment of associated psychotic and depressive symptoms. Further, when Alzheimer's Disease patients undergo cholinomimetic drug treatment subjects who show improvement in cognitive function show parallel improvement in patterns of brain activity. Such studies may result in strategies that could well improve the community care of these patients and could contribute to an overall strategy for patient care in the nursing home setting.

A significant aspect of care for Alzheimer's Disease patients is the stress that it places on the family responsible for providing support to the patient. Investigators have highlighted the guilt, demoralization, anger, and depression associated with this burden of care and have demonstrated the immunosuppressive effect of this chronic stress and higher rates of infectious illness among caregivers. Caregiving continues to be examined from the perspective of chronic stress and coping paradigms, which includes understanding factors affecting service use, and this line of research has now been extended to include Hispanic and black caregiving populations. The interpersonal interactions between caregivers and patients are being explored for ways to enhance patients functioning and decrease problem behaviors and inappropriate nursing home placement. There is now preliminary evidence which indicates that treatment interventions with caregivers can reduce, or prevent, further stress-related deterioration (e.g., mental health, burden, and perceived health), improve social support and decrease nursing home placement by 50 percent.

The long term (beyond 8 months) effects of treatment intervention continue to be examined.

In other area of psychopathology research, differential markers have been identified in late-onset schizophrenia and in depressive disorder. Sleep researchers have made progress in identifying potential markers for mild dementia, and potential treatment for sleep problems including "Sundowning" in dementia patients.

Research on acute treatment of depression in older patients has shown that treatment response to medications alone, and to psychotherapy alone, or both treatments combined, is substantial, though naturalistic followup has shown high rates of relapse and recurrence. Research to establish protocols for continuation and maintenance treatment is now underway.

Age effects on the pharmacokinetics of psychotherapeutic medications continue to represent a significant area of psychopharmacologic research as does concern with side effects such as cognitive toxicity of benzodiazepines and antidepressants and movement disorders associated with neuroleptic use.

Recent research has well documented the high suicide rates of the elderly—19 percent of all suicides occur among the elderly, with males over age 85 having the highest recorded rate. A number of demographic, behavioral, and psychopathologic differences between suicide in the elderly and other age groups have now been identified.

Comorbidity represents a serious and significant problem in the elderly. Comorbidity can lead to misdiagnosis and missed diagnosis. In addition, comorbidity can be a potential confound to treatment. Comorbidity is pervasive in geriatric populations. Nearly 40 percent of geriatric patients with major depression also met criteria for anxiety. As many as 30 percent of dementia patients also suffer from major depression, and can exhibit symptoms of agitation, paranoia, hallucinations, and sleep disturbance. Moreover, many medical illnesses can present with cognitive, emotional and behavioral problems or these problems may arise as a consequence of prescribed medications. Comorbidity creates a challenge for the development and use of pharmacotherapy with the elderly because they may have alterations in pharmacokinetics and drug metabolism changes with coexisting illness or polypharmacy, research in these areas is currently underway. Research on elderly patients with Non-Insulin-Dependent Diabetes Mellitus (NIDDM) has established an association between poor glycemic control (hypoglycemia) and decrements in cognitive and emotional functioning. Preliminary data on the treatment of NIDDM patients suggests that when the hyperglycemia is improved using the drug glipizide, learning, memory and attention were also slightly improved.

BASIC RESEARCH

The Institute provides support for basic research in the neurosciences, behavioral sciences, and in the area of health and behavior. General program areas include biological aspects of behavior; molecular biology; neurobiology; psychopharmacology; cognitive processes; personality, emotion, and psychosocial processes; factors influencing behavioral development and modification; biological; psychological, and psychosocial aspects of stress and other psychological states; behavioral medicine, psychoimmunology; and research on Acquired Immunodeficiency Syndrome (AIDS).

SERVICES RESEARCH AND DEMONSTRATIONS

The major report entitled *Caring for People with Severe Mental Disorders; A National Plan of Research to Improve Services*, issued in fiscal year 1991 by the National Institute of Mental Health and the National Advisory Mental Health Council in response to a congressional request, identified a number of areas for needed mental health services research in relation to mentally ill aged persons. The report called for more research in the area of rehabilitation and habilitation of older persons with mental illness. It also recommended greater research on the various organizational approaches that might best serve the mentally ill elderly. Studies are needed, the report noted, to evaluate the role of nursing homes in serving the mentally ill, including the impact of the nursing home preadmission screening program now in operation under the Omnibus Budget and Reconciliation Act of 1987 (OBRA 1987). Recommendations were also made for expanded research in the public financing of services for the severely mentally ill, including Medicaid and supported housing.

A number of Institute-funded grant and contract studies were completed or in process in Fiscal Year 1991 that will contribute to an expanding base of mental health services research related to the mentally ill elderly. A contract study, undertaken in collaboration with the Health Care Financing Administration (HCFA) as part of a larger congressionally mandated analysis, was completed by Dr. William C.

Hsiao and his colleagues at the Harvard University School of Public Health that demonstrated the feasibility of using a Resource-Based Relative Value Scale for reimbursement of psychiatrist services in the Medicare and Medicaid Programs.

The Fifth Annual NIMH International Research Conference on the Classification, Recognition, and Treatment of Mental Disorders in General Medical Settings held on Sept. 23-24 in Bethesda, MD, included research presentation in a number of areas related to the provision of primary care to mentally ill elderly persons. Technical papers were presented in the following areas: the prevalence of alcoholism that co-occurs with mental disorders in ambulatory elderly patients and its rate of detection by primary care by physicians, the detection of delirium in hospitalized elderly patients, and the incidence of mental status changes following elective surgery in older patients. The conference also heard research presentations on the impact of OBRA 1987 on the use of neuroleptic medications in nursing homes, and a report of a HCFA-funded study on the design and evaluation of a prospective payment system for the facility cost of outpatient care, including mental illness, under Medicare.

Research studies related to the mentally ill elderly in nursing homes examined medication practices. One of the first empirical studies of the impact of OBRA 1987 on mentally ill Medicaid recipients, including the elderly, using data from the Connecticut Medicaid program, was completed (see Research Highlights). Institute-supported researchers representing three grants at Memphis State University, the University of Illinois, and the Nathan S. Kline Institute for Psychiatric Research, New York State Office of Mental Health, presented preliminary findings on their research a panel on the effects of prospective payment systems on psychiatric hospitals at the 66th annual conference of the Western Economic Association International on June 30, 1991 in Seattle, WA (see Research Highlights).

The Institute-funded Center for Rural Mental Health Research, Department of Psychiatry, University of Arkansas for Medical Sciences, is conducting research on the role of disruptive and aggressive behavior as a precipitating risk factor for premature nursing home placement. The Center initiated planning for a series of studies related to mentally ill elderly persons, including the effectiveness of specific treatment interventions, the validation of outcome measures, and preferences of elderly clients and their informal caregivers for home and community-based services.

A team of researchers at Mount Sinai Medical Center, New York City, under the direction of Dr. George Fulop, is completing a study investigating the impact of co-existent medical and psychiatric disorders on the course and cost of hospital treatment of geriatric medical/surgical patients; a subanalysis in this project is exploring the contribution of demoralization and depression to prolonged hospital stays of elderly patients. One preliminary finding from this research indicates that elderly medical/surgical patients with depression have hospital stays 1.3 times longer than medical/surgical patients without comorbid conditions. A study directed by Dr. M. Catherine Hawes at Research Triangle Institute is being completed that is examining the prevalence and severity of mental status problems and disordered behaviors among nursing home residents, estimating various institutional responses to disordered behavior, and analyzing the characteristics of "exemplary or model" nursing home facilities that have low utilization of drugs and restraints relative to the number of residents exhibiting behavioral disturbances.

RESEARCH TRAINING

National Research Service Awards, including individual fellowships and institutional awards at the predoctoral or postdoctoral levels, provide support for the training of research scientists in the area of mental health and aging. The major orientation is toward postdoctoral training in departments and institutions with major research programs in mental health and aging. In particular, program emphasis in FY 1991 was to establish research training programs for basic and clinical scientists at each of the NIMH supported Clinical Research Centers.

CLINICAL TRAINING

In FY 1988 the NIMH established a new program, the Clinical Faculty Scholar award, to support the development of clinician scholar/investigators about to launch academic careers. This program was continued in FY 1991 and a program of institutional awards to support stipends for trainees was continued in each of the core mental health disciplines.

INTRAMURAL PROGRAMS

The NIMH intramural scientists are continuing to build a base of knowledge about the biological, psychological, cognitive and affective changes that occur through the aging process. A summary of the investigations now being conducted in the Unit on Geriatric Psychopharmacology, Laboratory of Clinical Sciences (LCS), and the research highlights from other intramural laboratories which relate directly to aging and Alzheimer's Disease are presented.

LABORATORY OF CLINICAL SCIENCE, UNIT ON GERIATRIC PSYCHOPHARMACOLOGY

Cell Culture Model

Of particular interest in the last year to the intramural investigators in the Unit on Geriatric Psychopharmacology in the Laboratory of Clinical Science has been the development of an innovative cell culture model to study the underlying cause of this enigmatic illness. Specifically, the intramural scientists have obtained cells from the nasal cavity of living Alzheimer patients and then successfully propagated them in the laboratory. These dividing cells show many characteristics of neurons from the brain and offer a unique opportunity to directly test different hypotheses regarding the cause of central nervous damage in dementia.

Pharmacological Studies

On the clinical front the intramural investigators in the Laboratory of Clinical Science are proceeding with a number of new drug studies. Some of these medication studies (e.g. scopolamine) are designed to establish better pharmacologic models of the memory deficit associated with Alzheimer's Disease, while others are more directly related to potential therapies (e.g. L-deprenyl, DHEA and physostigmine). As an example, the investigators are taking the lead in developing ways to safely combine treatment medications for patients with Alzheimer's Disease. While no single medication has been proven effective, the goal is to establish a method for synergizing the modest effects of multiple medications to create a more effective overall treatment strategy. This approach has proven successful in other major illnesses such as cancer and may well prove useful with the dementias. Together with the basic science studies these clinical projects afford a broadly based program in Alzheimer's Disease which is aimed at understanding the cause of the illness as well as toward the development of new therapies.

Cognitive Studies

Intramural investigators in the Laboratory of Clinical Science completed a series of studies that address the question of whether object naming and other word-finding problems in patients with Alzheimer's Disease are due to a loss of knowledge versus impaired retrieval from an intact knowledge store. Evidence has been obtained in support of a model that posits that damage to posterior regions of the temporal lobe results in an actual loss or degradation of the semantic representations of objects. These degraded representations are, in turn, proposed to be responsible for impaired naming and other types of word-finding problems in patients with Alzheimer's Disease. A related series of studies have explored the ability of Alzheimer's patients to learn and remember objects by contrasting performance under explicit recall conditions with indirect or implicit measures of recall. These studies have indicated that a partial or incomplete memory trace can be reactivated at a later time, thus suggesting that some form of cognitively-mediated memory may be preserved even in patients with widespread limbic and cortical pathology.

Calretinin

In the last two years investigators in the Laboratory of Clinical Science have been focusing their work on calretinin, a neuron specific calcium binding protein that they isolated and purified. The scientists have raised an antibody to this protein and have performed immunocytochemical, *in situ* hybridization histochemical, radiomunoassay, and biochemical studies which have revealed that calretinin is contained primarily in subsets of neurons in the brain and is present in all species studied. It is also present in human cerebrospinal fluid.

The following calretinin studies have been completed or are in progress: (1) A detailed mapping of calretinin immunohistochemical localization was completed for rat hindbrain. (2) An mRNA probe using human calretinin sequence was used for *in situ* hybridization histochemistry. Results indicated a distribution of calretinin

mRNA which is complimentary to previous immunohistochemical results. (3) Calretinin (100 nM) was shown to inhibit phosphorylation of a 39 kDa protein found in rat brain synaptic membranes. (4) A population of interneurons in dissociated cell cultures of embryonic rat cortex was found to express calretinin immunoreactivity. These neurons are relatively resistant to neurotoxicity induced by either glutamate, NMDA, kainic acid or quisqualate.

(5) In cerebellar granule cell cultures an unusual cell type was identified when contained dense calretinin immunoreactivity throughout the cytoplasm and nucleus. Interestingly, these cells are also relatively resistant to the toxicity observed in granule cells following glutamate, NMDA, kainic acid or quisqualate treatment. (6) In a study of neuronal degeneration, chick retinas were incubated *in vitro* in physiological buffers containing either glutamate, NMDA, or kainic acid. Neuronal degeneration was assessed by the resultant efflux of lactate dehydrogenase to the bathing medium. Treatment with NMDA or glutamate for one hour followed by a 24 hour incubation without drugs revealed the survival of numerous calretinin positive ganglion cells and cells within the inner nuclear layer, in addition to terminals within the inner plexiform layer.

These data imply that the calcium binding protein may confer protection to some neurons against excitotoxic injury. As with other calcium binding proteins, the suggested mechanism for this phenomenon is that calretinin may buffer increases and thereby protect against neurodegeneration.

RESEARCH HIGHLIGHTS FROM OTHER INTRAMURAL LABORATORIES/BRANCHES

Intramural scientists are using sophisticated imaging techniques and animal models as well as new classes of drugs and are continuing to build a base of knowledge about diseases afflicting the aged.

Galanin

NIMH intramural scientists continue to investigate the functional significance of neuropeptides coexisting within the same neuron as "classical" neurotransmitters in the awake, behaving rat. One case of coexistence which was the focus of experiments this year was galanin (GAL) and acetylcholine (ACH) in the septohippocampal pathway, relevant to new treatments for Alzheimer's disease. It was previously demonstrated that galanin inhibits the ability of acetylcholine to improve working memory in rats with ibotenic acid lesions of the nucleus basalis-medial septal areas. In collaboration with the University of Stockholm, intramural investigators tested the first galanin antagonists as memory enhancers and appetite suppressants. One putative galanin antagonist, M35, looks promising in its ability to block galanin-induced feeding and to increase performance on acquisition of the memory task.

Galanin research will continue using T-mazes for testing galanin fragments and potential galanin receptor antagonists for memory enhancement in animal models of Alzheimer's Disease. *In situ* hybridization will be utilized to investigate treatments that change messenger RNA for tyrosine hydroxylase and cholecystokinin in midbrain dopamine neurons, relevant to schizophrenia and drug abuse and for tyrosine hydroxylase and galanin in locus ceruleus neurons, relevant to stress and depression in both rat and human brain.

DNA Sequencing

NIMH intramural scientists in the Laboratory of Biochemical Genetics in investigating models of aging in the central nervous system have pioneered in the development of techniques to look at variations in the mitochondrial DNA. Mutations in the mitochondrial genome have been shown to be responsible for a number of diseases. It has been suggested that the accumulation of mutations in the mitochondrial (MT) genome may be associated with cellular aging, particularly in tissues such as the brain. CNS neurons may be vulnerable as they have a high rate of oxidative metabolism which can generate potentially damaging free radicals, and these cells cannot be replaced if they accumulate mt genome mutations. To investigate whether there is an accumulation of mutations in CNS human mt DNA with aging, the investigators analyzed cloned DNA from the retina of a 77 year old person. The predictions indicated that there should be 1 base pair change per 9; the actual result was a single base pair change out of 32,000 base pairs of DNA. A much lower accumulation of mutations was observed than that predicted by the reported error rate for the DNA polymerase that replicates this genome. These results indicate that DNA repair mechanisms must be active in the mitochondria.

AAPP

The investigators in the NIMH intramural Laboratory of Biochemical Genetics (LBG) in collaboration with Mt. Sinai Medical School have been examining protein variations in the brains from patients who died from Alzheimer's Disease. The investigators have observed a diminished translation efficiency of Alzheimer's Disease brain polysomes. This decreased efficiency may be due to a modification of elongation factor two, a protein essential in protein synthesis, which was found in post-mortem tissue from the patients with Alzheimer's Disease. In addition, the scientists have also continued the exploration of animal models for this disease. They have demonstrated protein differences in the brains of rats lesioned unilaterally by administration of NMDA into the rostral and caudal aspects of the nucleus basalis. There is a 2.6 fold increase of Alzheimer Amyloid Precursor Protein (AAPP) in the cerebral cortex on the lesioned side of the rat brain as compared to the nonlesioned side of the same brain. The overall protein synthesis remained unchanged and glial fibrillary acidic protein (this protein is a marker for nonspecific brain trauma) synthesis was unaffected.

Primate Neuroplasticity: Adult Brains Grow New Neuronal Connections

NIMH intramural scientists in the Laboratory of Neuropsychology have found that the central nervous systems of adult primates may recover from injury much more fully than previously believed. Areas of the brain, deprived of their normal activity may assume new functions, a phenomenon called neuroplasticity. Rewiring of the brain is routine in infant animals and humans, but until recently, it was thought that "plasticity" hardened in the adult brain to become permanent. Tests of the so-called "Silver Spring Monkeys," revealed that, 12 years after nerves in the arms were cut, a half-inch long stretch of brain tissue normally devoted to impulses from the arm had been reorganized to process signals from the face. The scientists theorize that in the future with elucidation of the mechanisms by which these changes occur, it may be possible to encourage neural reorganization to restore function after nerve or brain damage.

Cerebral Dysfunction in Aged Monkeys

Studies in normal aged monkeys by the NIMH intramural investigators in the Laboratory of Neuropsychology, conducted in collaboration with investigators from The Johns Hopkins University School of Medicine, indicate a gradual decline in learning and memory abilities with normal aging. This decline was apparent in spatial abilities as early as the late teens but did not affect cognitive memory or habit formation until the late 20's, indicating that the cerebral systems underlying spatial abilities are compromised earlier than others. At the same time the behavioral impairments within a given task vary greatly from one aged animal to another, suggesting that different animals have different patterns of cerebral involvement. This possibility is currently being investigated directly through postmortem localization of enuretic plaques and depletion of cholinergic and other neurotransmitters.

Somatostatin

The NIMH intramural Biological Psychiatry Branch continue studies of somatostatin in relation to neuropsychiatric disorders. Some of their findings show that somatostatin is low in Alzheimer's Disease and is significantly correlated with measures of both depression and cognitive impairment in these patients. Low CSF somatostatin also has been linked to indices of cortisol hypersecretion.

Longitudinal Study on Reciprocal Effects of Social Environments and Psychological Functioning

The NIMH intramural Laboratory of Socio-Environmental Sciences has begun a new initiative in collaboration with the National Institute on Aging. The study involves the Laboratory's long-term longitudinal investigation of the reciprocal effects of social environments and psychological functioning, and the focus this time is on older people. The research from the 1964-74 survey demonstrated that the complexity of social environments (e.g., the job or the home) has a positive effect upon cognitive functioning. Regardless of their age, workers engaged in more substantively complex and self-directed jobs were more likely to have improved in their cognitive functioning over 10 years than those engaged in less complex jobs.

The empirical basis for this new study would be a resurvey of a sample of men and women last interviewed in 1974 as part of the Laboratory's research program

on the psychological effects of occupational conditions. Some of the questions to be addressed by this study include: (1) Are the relationships between environmental complexity, self-directed orientation, and intellectual flexibility the same for older adults as they were at earlier times in their lives? (2) What are the factors and conditions that affect the levels of environmental complexity that older individuals encounter? (3) How does the nature of past social environments influence retirement decisions, and how does the nature of the post-retirement environment affect psychological functioning? What are the roles of social support or physical health in this process?

At the present time the investigators are in the process of locating the respondents and have begun a series of pre-tests which will maximize the respondents' recall of the important occurrences in their lives in the more than a decade and a half that has gone by since they were last interviewed.

DHHS COUNCIL ON ALZHEIMER'S DISEASE

The DHHS Council on Alzheimer's Disease is essentially the former DHHS Secretary's Task Force on Alzheimer's Disease renamed. The Council was established by the Alzheimer's Disease and Related Dementias Services Research Act of 1986 (Title IX of PL 99-660). Key functions of the Council include identifying promising areas of Alzheimer's Disease research, coordinating this research, sharing information, and facilitating the translation of the research into practice. The Council is chaired by the Assistant Secretary for Health. Other membership consists of; the Surgeon General; the Assistant Secretary for Health Planning and Evaluation; the Commissioner of the Administration on Aging; the Administrator of the Agency for Health Care Policy and Research (AHCPR); the Directors of the National Institute on Aging (NIA), National Institute of Mental Health (NIMH), National Institute of Neurological Disorders and Stroke, National Institute of Allergy and Infectious Diseases and National Center for Nursing Research; and representatives of the Department of Veterans Affairs, Health Care Financing Administration (HCFA), Health Resources and Services Administration, and National Center for Health Statistics.

The Council meets twice annually, and is required to submit an annual report to Congress and to the public detailing the plans of four member agencies (NIA, NIMH, AHCPR, and HCFA) regarding research on services for dementia patients and their families. Prior reports, which have been submitted in January of each year since 1988, have also detailed progress in federally sponsored Alzheimer research supported by all member agencies of the Council. The Council met most recently in September 1991 to discuss the draft of the next report/update of plans. The NIMH plan in this regard was mandated to provide for research concerning: (a) mental health services and treatment modalities relevant to mental, behavioral and psychological problems associated with Alzheimer's Disease; (b) methods for providing comprehensive multidimensional assessments; (c) the optimal range and cost-effectiveness of community and institutional services; (d) the efficacy of special care units; (e) methods of combining the services of health care professionals with informal support services provided by family and friends; (f) interventions to reduce the psychological, social and physical problems of caregiving family members; and (g) methods of improving service delivery. NIMH received a special \$2 million appropriation in FY 1988 to support such research on Alzheimer's Disease services, but no specific such appropriation since then.

DHHS ADVISORY PANEL ON ALZHEIMER'S DISEASE

The DHHS Advisory Panel on Alzheimer's Disease was established by Title IX of Public Law 99-660 ("Alzheimer's Disease and Related Dementias Services Research Act of 1986") to assist the DHHS Secretary and DHHS Council on Alzheimer's Disease in identifying priorities and emerging issues regarding Alzheimer's Disease and related dementias, and the care of afflicted individuals. The Panel is composed of 15 non-Federal appointees who are prominent researchers or other experts on Alzheimer's Disease, and five members of the DHHS Council (including the NIMH Director) who serve *ex officio*. Members serve for the 4-year life legislated for the Panel (FY 1988-91).

The Panel is mandated to center its advice on emerging issues and promising initiatives, or research directions, in four areas related to Alzheimer's Disease: (a) biomedical research; (b) research on services for Alzheimer's patients and their families; (c) home and community based service provision systems; (d) financing of health care and social services. The Panel is required to prepare annual reports (transmitted to Congress, the Secretary of HHS, the DHHS Council on Alzheimer's Disease,

and the public) giving recommendations for administrative and legislative actions to improve services and provide for promising biomedical research.

The Panel issued its first annual report in 1989, and has met on three subsequent occasions in 1989, 1990, and 1991 to work on its yearly reports. Its second, 1990 report, became available in published form in 1991. It included an update on topics covered in the first report, such as biomedical and services-oriented Alzheimer research, financing of care, and eligibility for services, addressed the specific topic of personnel and training issues in the care of Alzheimer victims. For its third report, the Panel will update topics discussed in previous reports, and will introduce a framework to consider the values and goals in the care of Alzheimer's patients in hopes of influencing better service delivery. In addition, a supplemental report dealing with ethnic minority and crosscultural issues in Alzheimer's Disease is also being prepared.

EXTRAMURAL RESEARCH HIGHLIGHTS

IMAGING

Imaging studies refer to research utilizing position emission tomographic (PET), magnetic resonance imaging (MRI), and computer-analyzed electroencephalography (e.g., electrophysiological mapping procedures). This new technology is being used in the exploration of diagnostic markers of a number of late-life mental illnesses, as well as tracking brain changes that may result from treatment. The association between age of onset and the presence of structural brain pathology is being investigated in both late onset schizophrenia (LOS) and late onset depression. Increasingly, researchers using imaging techniques are attempting to integrate clinical, neuroanatomic and neurobehavioral data.

Gary Small, at the UCLA Neuropsychiatric Institute (MH46424 FIRST award), is utilizing PET scanning technology to test his hypothesis that persons with Age-Associated Memory Impairment (AAMI), who have one or more first-degree relatives with clinical diagnosed or neuropathologically confirmed Alzheimer's Disease (AD), will show a high frequency of atypical brain glucose metabolic patterns. These AAMI relatives should be discernable from age-matched elderly without AAMI, and negative for a family history for AD. Other potentially discriminating ratios and patterns (e.g., parietal/sensorimotor, hemispheric asymmetry, local metabolic rates) are also being examined.

Andrew Leuchter, University of California, Los Angeles (MH40705) has developed computer-analyzed electroencephalography (CEEG) more fully as a tool for differential diagnosis of dementia and he is exploring the establishment of links between brain functional abnormalities seen on CEEG and structural lesions seen on MRI scans. In his initial work Leuchter found that there are age-specific EEG changes that need to be considered in differential diagnosis and that by using age-corrected CEEG techniques he can achieve an 85 percent accuracy rate in the differential diagnosis of AD, multi-infarct dementia, and normal subjects. With regard to the linkages between CEEG and MRI, he has identified an electrophysiological marker—decreases in absolute slow-wave power, with concomitant increases in relative slow-wave power in the cortex overlying the lesion—for functionally significant deep white-matter ischemic disease that appears on MRI.

Dr. Leuchter has applied his methods for the mapping of brain electrical activity to a series of patients with Alzheimer's Disease who were undergoing cholinergic drug treatment. Subjects were followed with serial brain mapping studies as well as neuropsychological testing. Subjects who showed improvement in cognitive function showed parallel improvement in patterns of brain electrical activity that were similar across subjects; nonresponse was correlated with a different brain electrical activity pattern.

In addition, Dr. Leuchter has also demonstrated the usefulness of EEGs, EEG coherence, and spectral ratios in diagnostic testing with geriatric populations.

Dr. Leuchter recently reported findings, based on the largest scale study to date, of the clinical value of EEG, in the diagnosis and assessment of patients with possible dementia. In this study of 350 subjects with possible dementia as well as normal controls, they discovered that even with equivocal cognitive impairment (MMSE score 24-30), there was a 49 percent prevalence of EEG abnormalities; this was more than four times the rate seen among normal controls, indicating that EEG may be useful as a diagnostic test among mildly impaired patients.

Previous studies have found that Alzheimer's Disease is associated with characteristic findings on neuropathology (senile plaques and neurofibrillary tangles) that are most prominent in the posterior brain regions and that this neuropathology appears

to be highly correlated with characteristic findings of hypometabolism and hypoperfusion on PET and SPECT scanning. Dr. Leuchter has now identified with quantitative EEG parameters are most closely associated with this posterior brain pathology. In a study of 116 subjects, he examined several quantitative EEG (qEEG) parameters and demonstrated that ratios of EEG spectral power (spectral ratios) show a stronger topographic relationship with patterns of hypoperfusion, hypometabolism, and neuropathology than does absolute power alone. A new type of ratio measure has been found that appears to be useful in distinguishing subjects with multi-infarct dementia from those with Alzheimer's Disease.

Based on evidence that much of the cognitive impairment seen among subjects with Alzheimer's Disease may be due to selective degeneration of long cortical fibers joining different brain regions, Dr. Leuchter and his colleagues examined fiber tracts and functional connections using EEG coherence. They demonstrated that there is functional disassociation between parietal and prefrontal cortex among Alzheimer's subjects. They also found that many local connections in the pre-Rolandic and post-Rolandic cortex are disrupted among subjects with multi-infarct dementia. They suggest that EEG coherence appears to be the only brain imaging techniques that is capable of measuring these changes in brain connectivity.

Ira Lesser, at the Harbor-UCLA Medical Center (MH43960) is using MRI and batteries of neuropsychological tests to examine the relationship between brain injury and late-onset depression (LOD). Subjects with late onset depression (first episode of depression after the age 50), but who are otherwise medically healthy and nonmedicated are being compared to a group of currently depressed nonmedicated patients over the age 50 who had their first depressive episode before the age of 35 (recurrent depression), and to psychiatrically and medically healthy, age matched control subjects. Dr. Lesser hypothesizes that late onset depressive patients will have more evidence of brain injury (primarily vascular disease) and a higher frequency of frontal and subfrontal (periventricular) white matter lesions than either of the control groups. Preliminary MRI data comparing eight LOD patients to four elderly recurrent depressives supports this hypothesis. Only one in four of the recurrent depressives had appreciable amounts of white matter disease in the periventricular area (4.6 cm²) compared to 50 percent of the LOD patients who had lesions greater than 3 cm (mean total white matter lesions 6.3 cm²). Convergent preliminary data from the neuropsychological batteries suggests that the LOD patients demonstrate dysfunction in frontal lobe function on neuropsychological tests when compared to their late-onset counterparts.

Peter Rabins, of Johns Hopkins University (MH 40843), is using MRI scans and neuropsychological evaluations to discern possible differences among elderly who have either a major depression, Alzheimer's Disease, or are normal. Specifically, he is examining whether: (1) depressives have more cortical as well as subcortical abnormalities compared to normals, but less than AD patients; (2) clinical variables in depressives (activities of daily living, neuropsychological performance, response to depression treatment) correlate with MRI changes; (3) MRI lesions are prognostic for depressed patients. It is expected that increased lesions will be associated with relapse and the development of AD and functional impairment. In addition, Dr. Rabins is further characterizing language disorder of the dementia syndrome, and is correlating it with basal ganglia lesions, left temporal lobe volume, and left superior temporal gyrus volume.

Mony de Leon, at New York University Medical Center (MH43965), using a special negative angle protocol in computerized axial tomography (CT) and MRI studies of normal elderly and Alzheimer's Disease patients, has found hippocampal atrophy very early in the AD course. Once AD is clinically evident, longitudinal PET and CT assessment has indicated lateral temporal lobe degeneration. Moreover, in AD patients *in vivo* hippocampal atrophy, hypothalamic-pituitary-adrenal (HPA) axis dysregulation and PET glucose utilization deficits have been found. Because a reduction in brain microvessel glucose uptake has been found postmortem, Dr. de Leon has proposed a "brain glucose starvation hypothesis" in the pathogenesis of AD that is related to hippocampal dysfunction. Dr. de Leon is attempting to use PET to extend the CT and MRI finding that the hippocampal change is among the earliest brain changes in AD.

At the Duke University Clinical Research Center (MH40159), Edward Coffey is comparing MRI structural brain measures (volume, cortical atrophy, T2 signal intensity in the pons, subcortical white matter, and deep grey nuclei), and computerized EEG parameters among normal elderly, and depressed elderly referred for electroconvulsive therapy (ECT). Dr. Coffey found pre-ECT depressed elderly to have more frequent and severe MRI brain abnormalities than normals (cortical atrophy, periventricular hyperintensities, basal ganglia/thalamic lesions), including EEG ab-

normalities that appear correlated with lesions of subcortical gray matter. He has also found that *late onset* depressives in particular, had more cortical atrophy. In terms of response to ECT, Dr. Coffey's preliminary analyses indicate that depressed patients with more brain abnormalities (MRI and EEG) are less responsive (maintain more depressive symptoms) to ECT. Although most elderly depressed patients respond to ECT, cortical atrophy that is related to delayed orientation post-ECT and lesions of the basal ganglia (such as caudate atrophy), may be related to the development of interictal delirium in ECT treatment. Diffuse cortical and/or subcortical lesions in depression may disrupt neurotransmitter pathways and thus produce "neurochemical disconnection syndrome" with resultant affective and cognitive disturbances. Subcortical brain changes appear to be associated with less melancholia and more dementia symptoms in elderly depressed patients. Moreover, short REM latency in depression (see Reynolds, under Sleep) may be associated with lesions of the pons.

Dr. Walton Roth (MH40052, Stanford University), a leader in the field of event-related potential (ERP), is developing and refining an event-related potential paradigm which he hypothesizes can elicit cognitive components from patients who are unable or unwilling to perform simple tasks. This would provide researchers with electrophysiological measures of automatic and effortful cognitive operations that could be used with Alzheimer's Disease patients whose illness had progressed to a state where other methods were no longer appropriate.

MOLECULAR GENETICS AND MOLECULAR BIOLOGY

The search for a cause of Alzheimer's Disease has become increasingly critical. Genes today comprise the only etiologic factor successfully identified, and thus provide a critical clue to uncovering the mystery of this disease. In his earlier research (MH43240), Dr. Leonard Heston now at the University of Washington, discovered a remarkable etiologic clue to Alzheimer's Disease in the form of an association with Down's Syndrome: he found that all individuals with Down's achieving 40 years of age develop the neuropathology of AD, with similarities extending to light and electron microscopic changes, enzymatic changes and the anatomical distribution of lesions. A second link between these two conditions has also been confirmed in Heston's epidemiologic work, wherein a significant excess of Down's syndrome births were found in families identified because of a case of Alzheimer's Disease. Heston has hypothesized that the excess gene product present in Down's, because of the trisomic chromosome 21, must be a first suspect for causing pathology in Down's, and by extension, a DNA sequence on 21 could be associated with AD in disomic individuals.

A small subset of persons with AD have families in whom approximately 50 percent of individuals in each generation develop AD, and these "familial AD" victims have been found to have an abnormal gene on 21. Because the gene for the precursor of the abnormal amyloid protein found in brain plaques in AD was also shown to reside on chromosome 21, the hypothesis evolved that the over-expression of this amyloid protein gene predisposed individuals to Alzheimer's Disease. However, further restriction fragment length polymorphism (RFLP) linkage analysis has indicated that the amyloid gene is not linked to the locus for familial AD, indicating that the amyloid protein is probably not responsible for the AD syndrome but is incidental to the disease process.

George Zubenko of the University of Pittsburgh (MH43261 and Research Scientist Development Award MH00540) has continued to extend and clarify his initial findings of a blood platelet abnormality, namely, increased membrane fluidity, in Alzheimer's Disease patients. He has evidence that this membrane abnormality identifies a subgroup of patients with distinct clinical features—including an earlier symptomatic onset, a more rapidly progressive decline, and greater likelihood of a family history of dementia—and that it appears to be a stable, familial trait vertically transmitted in families through inheritance of a highly penetrant autosomal gene. Most recently, Zubenko has discovered that the genetic locus (called PMF) for this trait may reside on the long-arm of chromosome 21, where several other genes related to the biology of Alzheimer's Disease have previously been localized. He is now beginning to do a linkage analysis study to determine whether the PMF locus does definitively map on this region of chromosome 21 and whether it is distinct from the genes for familial Alzheimer's Disease and the amyloid precursor protein, or may be located more closely with a region associated with the development of Down's syndrome. This work is progressing rapidly, and has exciting potential both for clarifying the etiology of Alzheimer's disease and for yielding a biological marker useful in the diagnostic identification of a particular subtype of the disease.

At Albert Einstein College of Medicine, Dr. Peter Davies (MH38623) has discovered an abnormal protein called A-68 in the brains of patients with Alzheimer's

Disease; this discovery may illuminate the origins of the disease and ultimately lead to a clinically useful diagnostic test for the disorder. Using a monoclonal antibody that he developed (known as ALZ-50) to proteins that are unique to cholinergic nerve cells, Dr. Davis found that the antibody identifies the abnormal AD-associated protein in the temporal and frontal brain cortex of 85 percent of AD patients, whereas the protein is not correlated with severity of clinical dementia, neuritic plaques, or old age per se. Research to determine whether the protein can be reliably assessed in the blood or cerebrospinal fluid of living patients is continuing. Recently, the protein was reported to be present in cerebrospinal fluid of some AD patients, and to be transiently expressed very early during the course of human brain development. Dr. Davis is currently producing both polyclonal and monoclonal antibodies that will be used in the assay of the cerebrospinal fluid to increase sensitivity and specificity of the test.

Other important leads associated with pathogenesis of Alzheimer's Disease have emerged from the work of Dr. Carol Miller of the University of Southern California (MH39145), who has applied monoclonal antibody and DNA technologies to CNS tissue obtained from Alzheimer's Disease patients at autopsy. She has identified different localized networks or subpopulations of neurons which are differentially affected in AD. Moreover, her results reveal the unfolding of a systematic time course of immunocytochemical changes in the CNS tissues patients dying from 1 to 16 years post diagnosis.

Dr. Miller has also discovered the presence of selective optic nerve degeneration in AD, together with the manifestation of histologic and Ultrastructural abnormalities in the retinas of patients with AD, as contrasted with age-matched controls. In all AD cases, the pathology was limited to the ganglion cell layer, with marked dropout of ganglion cells and nerve fiber layer atrophy present in the most severely affected retinas. Although the extent of retinal damage failed to correlate with the severity of AD changes in the brain, it is notable that there were no neurofibrillary tangles within the ganglion cells or neurotic plaque or amyloid angiopathy in the retina. Dr. Miller is currently exploring the neuronal-specific function of the affected neurons at three levels: clinical, histologic, and molecular. The clinical studies will focus on the visual system, integrating the neurologic and psychometric database with specific visual studies. A parallel histologic assessment of auditory system neuronal changes is being conducted. With the use of neuron-specific monoclonal probes, the architectonic differences in neuronal changes in AD will also be compared with those in other dementing diseases, such as Pick's, and Parkinson's.

At the University of Rochester Clinical Research Center (MH40381), Dr. David Felten and colleagues are among the first researchers to explore neural-immune interactions in aged rodent models, and to test preliminary hypotheses related to psychopathology in the elderly that may have an effect on immune responses. Among Dr. Felten's findings, aging associated decline in noradrenergic and peptidergic innervation has been found in secondary immune organs (e.g., spleen and lymph nodes), but not in any primary immune organs. Age related declines in the presence of striatal and dopamine neurons can be slowed appreciably by the use of the potent presynaptic D₂ receptor agonist pergolide.

At the Case Western Reserve University Center for Clinical Research (MH43444), Dr. Steven Younkin is assessing the impact of Alzheimer's disease on choline acetyltransferase (ChAT), acetylcholinesterase (AChE), ChAT mRNA, and various molecular forms of AChE and of AChE mRNA in cholinergic neurons. He is assessing the gross pathology of noradrenergic neurons in the locus ceruleus of AD patients and will examine the expected correlated changes with AD-related behavioral variables.

Dr. Charles Nemeroff, at Emory University (MH40524) is examining neurochemical changes in Alzheimer's disease using post-mortem brain tissue obtained at both rapid (20-60 minutes after death) and conventional autopsy. This research is particularly exciting because of the unique availability of substantial numbers of fresh, unfrozen brains. The availability of these fresh, unfrozen tissues allows Dr. Nemeroff and his colleagues, to conduct *dynamic* studies of the disruptions in cholinergic, somatostatin (SRIF), corticotropin-releasing factor (CRF) and -aminobutyric acid (GABA)-containing neuronal systems in Alzheimer's disease. Specifically, the investigator is examining, in detail, the dynamic state of cholinergic neurons including: markers of neuronal integrity, neuronal activity, the choline transporter itself, receptor number and affinity, and second messenger and third messenger responses (protein phosphorylation).

In addition, Dr. Nemeroff is exploring the peptidergic (SRIF and CRF) system in Alzheimer's Disease including assessment of the relationship between CSF and brain concentrations of these peptides. SRIF receptor subtypes will be measured, as will the functional responses of these receptors. Dr. Nemeroff will also examine the

relationship between the presence of the abnormal AD-associated protein, ALZ 68, and alterations in cholinergic and peptidergic neurons.

Recent investigations into the nature of cholinergic lesions in the brains of patients with dementia of the Alzheimer's type and Parkinson's Disease, both demented and nondemented, have revealed a major loss of subcortical cholinergic cells and cortical nicotinic cholinergic receptors. This neurochemical deficit, shared by the two disorders, is being examined by Dr. Paul Newhouse, at the University of Vermont (MH46625). Dr. Newhouse is employing a logical sequence of pharmacological probe challenges with assessment of their behavioral impact in several human populations. Dr. Newhouse is conducting three innovative studies. The first study will examine whether acute administration of the central nicotinic antagonist mecamylamine, to Alzheimer's Disease (AD), non-demented Parkinson's (PD) patients, and normal volunteers produces cognitive impairment, and whether dose-response curves differ across young and old normals and AD and nondemented PD patients. The second study will examine whether repetitive acute nicotine administration improves subcortical cognitive deficits found in DAT and PD and whether tolerance develops to this effect. Dr. Newhouse suggests that tolerance may explain why chronic anticholinesterase therapy in AD has been disappointing. In his third study, Dr. Newhouse will examine the specificity of the response to acute nicotine by evaluating whether mecamylamine can prevent cognitive and behavioral changes produced by nicotine in AD and PD patients and elderly normals. In all three studies, Dr. Newhouse is employing state-of-the-art computerized testing with newly developed testing paradigms, that will enable precise assessment of the effects of these agents on the cognitive functions implicated in nicotinic dysfunction.

SCHIZOPHRENIA

Late-onset schizophrenia (LOS) has received recent attention in several investigations supported by MDARB. Godfrey Pearlson at the Johns Hopkins University [MH43326] is examining the clinical, structural, and dopamine D2 receptor brain changes associated with LOS using MRI, CT and PET scanning. Clinically, he has found that LOS patients compared to same aged early-onset schizophrenics (EOS) have significant phenomenologic similarities (the presence of hallucinations and delusions) as well as differences. In a chart review of 54 LOS patients and 22 EOS patients he found that the LOS patients are more likely to have visual, tactile, and olfactory hallucinations; a greater number of different types of hallucinations; persecutory delusions; premorbid schizoid personality traits; more premorbid visual and sensory deficits; and less thought disorder and affective flattening. LOS were also less likely to have a family history of schizophrenia than were early onset patients (16.7 percent vs. 31.8 percent 0. LOS patients generally respond positively to neuroleptic medication—with 74 percent having either a complete remission or partial response. Structurally, using MRI, Pearlson and his colleagues at Hopkins found that patients with early-life onset schizophrenia have reduced volume of superior temporal gyrus. He has now extended this finding to LOS. In this seminal study, volumes of medial and lateral temporal lobe structures were assessed in 11 patients with LOS, 18 normal elderly controls, and 12 patients with moderate impairment due to Alzheimer's Disease. While both patient groups had smaller volumes of medial temporal regions (hippocampus, amygdala, entorhinal cortex), schizophrenics had significantly smaller superior temporal gyri than both normal controls and AD patients. Superior temporal gyrus shrinkage could not have been accounted for by general brain atrophy.

Dilip Jeste, at the University of California, San Diego (MERIT award MH43693), is examining the neuropsychological, brain-imaging, and treatment response characteristics of LOS and anticipates finding several subtypes. He predicted that one subset of patients will have significant neuropsychological deficits and structural abnormalities in MRI, and poor therapeutic response to neuroleptics with greater risk of tardive dyskinesia. Another smaller subgroup is expected to have a diagnosable dementing disorder that initially presents with schizophrenia-like clinical symptoms.

Those elderly who have suffered a chronic mental illness, such as *early* onset of schizophrenia, are also being studied in the NIMH program. Neuroleptic-induced tardive dyskinesia can be a significant problem in chronically mentally ill order patients for several reasons; the risk of TD increases considerably with aging, the length of neuroleptic exposure necessary to produce TD tends to be much shorter in older adults and is more likely to be severe and persistent, with far likely more adverse impact with low remission rates. In order to determine the incidence of TD in older patients, and to determine the risk factors for occurrence and precipitation of TD (including malignant TD), Dr. Jeste (MH45131-02) is assessing elderly psychiat-

ric patients over a 5-year period, many of whom have had less than 1 month of total lifetime neuroleptic exposure. After initial psychiatric and neurologic examinations, patients are being randomly assigned to one of two neuroleptic treatments where they receive the effective lowest dosage of either haloperidol or thioridazine and are followed-up with psychiatric and neurologic examinations. (see Jeste, under Treatment)

Michael Davidson (MH46436-01), at the Mount Sinai School of Medicine, is attempting to discern whether the dementia that appears in elderly schizophrenics shares a similar neurohistological substrate to that found in Alzheimer's or Multi-Infarct Dementia. Although the neurohistology of Alzheimer's Disease is well known, the neurohistology of schizophrenia remains to be documented. Dr. Davidson and his colleagues are conducting functional and cognitive assessments antemortem in elderly schizophrenic patients and will be following them until death, when their brains will be neurohistologically assessed. Insight into the etiology and neuropathology of a schizophrenic "dementia" has practical and theoretical importance. If dementia in schizophrenia shares the same histopathological substrate with Alzheimer's Disease, pharmacological interventions enhancing cholinergic activity could be applied to the demented schizophrenic population. On the other hand, a "dementia" unique to schizophrenia would promote investigations of the etiology of the cognitive decline in this illness, and could be an important clue to the underlying pathogenesis of schizophrenia.

In addition to research on the clinical course, neuropathology, and treatment of early and late onset schizophrenia, studies of the relationships among various psycho-social, environmental, and health factors that may influence service utilization, and the success of formal or informal care is being undertaken.

Dr. Carl Cohen, at the Health Science Center at Brooklyn, State University of New York (MH45780) is examining the mental health of older homeless women. This is the first time that this population, which comprises approximately one-fifth of all homeless women, has been studied. Using survey and ethnographic techniques, and in-depth interviews, 250 older homeless women living in shelters and on the streets of New York City are being examined to determine: demographic profiles; subsets of the population such as the mentally ill and substance abusers; pathways to homelessness; social networks and their relevance to survival; psychological/phenomenological aspects of the homeless condition; and the environmental/social context of homelessness. Findings from this study will be contrasted to previous research conducted by Dr. Cohen which examined similar factors among homeless older men (MH00523, MH37562).

Suzanne Meeks, at the University of Louisville (FIRST award MH44787), is following four age cohorts of middle-aged and elderly individuals with psychiatric diagnoses of schizophrenia, schizo-affective disorder, bipolar disorder, major depression, delusional disorder, or atypical psychosis over 5 years. Her study will attempt to determine how health and mental health services, social supports, family stressors and other factors affect adjustment (e.g., relapse) in these chronically mentally ill elderly. By identifying factors contributing to better outcome, interventions to improve the functional independence of the CMI elderly may be made.

Work by Jan Greenberg (MH46564-01) at the University of Wisconsin, explores the burdens experienced by elderly parents who care for adult children with a severe mental illness, many of whom are schizophrenic. Specifically, Dr. Greenberg is assessing the older parents' objective and subjective burdens, and is identifying potential factors associated with lower levels of burden (e.g., relatively fewer negative symptoms and unpredictable behaviors of adult schizophrenic children), and the extent to which formal services to the mentally ill adult child and the family serve as a buffer to the older parents.

SLEEP, DEMENTIA, AND DEPRESSION

Although electroencephalographic (EEG) abnormalities in demented patients were first reported over 40 years ago, gross slowing of the dominant frequency proved to be a nonspecific finding and only patients with advanced dementia could be differentiated from the normal elderly using such criteria. More recently, however, Dr. Patricia Prinz at the University of Washington (MH33688) has used sleep EEG activity as a biological marker to discriminate mild dementia from normal aging and from depression. Dr. Prinz has speculated that, since many of the earliest changes in AD involve presynaptic cholinergic nerve terminals originating in the basal forebrain, the EEG may provide a sensitive approach toward assessing these early neuronal changes. She has found that the degree of dominant occipital frequency, in conjunction with measures of percent wakefulness, correctly classified 85 percent of normal aged from mildly demented subjects. Because the accuracy of formulating a

different diagnosis in the earliest stages of disease has heretofore been so poor, and has constituted a major obstacle to longitudinal studies of the course of illness, Dr. Prinz's finding represents a highly significant development in the ongoing search for reliable biological markers in AD.

In his ongoing studies of sleep in late life mental disorder, Charles F. Reynolds III, of the University of Pittsburgh (Research Scientist Award, MH00295; and MH37869) has made a number of key observations concerning the prognostic significance of EEG sleep changes in late-life depression: (a) pretreatment REM latency was significantly lower in depressed geriatric patients who would suffer recurrence compared with those who remained well during maintenance drug therapy; (b) early REM sleep rebound and an antidepressant response to one night of total sleep deprivation correctly predicted in 88 percent of cases which patients would show a course consistent with depressive pseudodementia versus progressive dementia, with demented patients showing the lowest rate of REM activity generation; and (c) 2-year mortality in patients with mixed depression and cognitive impairment was correctly predicted in 77 percent of cases by lengthened REM latency and increased apnea-hypopnea.

Based on his observation that a "lag" in sleep recovery in the elderly may indicate a risk for future depressions, Dr. Reynolds is now conducting several longitudinal studies where he is continuing to clarify the relation between persistent sleep abnormalities, pathogenesis, and illness course. One study is following unipolar depressive patients who are currently in maintenance therapy; a second of patients with spousal bereavement or bereavement-related depression, and a third consisting of healthy elderly (who are nondepressed, nonbereaved). Dr. Reynolds found that the depressed bereaved elderly subjects had lower sleep efficiency, more early awakening, shorter REM latency, higher REM percent, and lower rates of delta wave generation in the first NREM period. The sleep of the depressed bereaved subjects resembled that of an age-, sex-, and severity-matched group of elderly patients with recurrent unipolar depression. Sleep in the nondepressed bereaved, by contrast was more like that of healthy control subjects. (see Reynolds, under Treatment)

Up to 30 percent of the elderly population complains of sleep difficulties, with impaired quality of life as a frequent outcome. Charles Morin, Virginia Commonwealth University (MH47020 FIRST award), is exploring the relative effectiveness of cognitive behavior therapy, pharmacotherapy (tenazepam), and the combination of cognitive behavior therapy and pharmacotherapy. Treatment outcome will be assessed in terms of sleep quality, mood, and neuropsychological functioning, and health service utilization.

Poor sleep may indeed account for the disproportionate prescription of sedative hypnotics in the elderly. Hypnotic use may lead to exacerbation of sleep apnea and daytime carryover effects such as sedation, falls, cognitive impairment, and anterograde amnesia. Thus, alternatives to pharmacotherapy approaches to sleep problems are also needed. Michael Vitiello at the University of Washington (MH45186) is examining the effects of increased aerobic fitness of sleep quality, assessed both subjectively and in terms of such objective outcomes as increased circadian temperature amplitude, increased nocturnal growth hormone and somatomedin-c levels and decreased nighttime norepinephrine levels.

Jerome Yesavage, Stanford University (MH45143), is also testing a nonpharmacological treatment for sleep problems: Sleep Restriction Therapy (SRT). The elderly often report higher frequency of naps compared to younger adults. However, daytime sleepiness that often co-occurs with naps may lead to decrements in cognitive functioning. SRT improves sleep quality by restricting excessive time in bed and allowing modest accrual of sleep debt resulting in consolidated sleep. The efficacy of a modified SRT intervention, allowing one 30 minute daytime nap, is also being assessed. Whether these treatments have an effect on pretreatment levels of depressive symptoms will be tested as well.

Sleep difficulties also appear in dementia patients, with severe problems often leading to institutionalization of the patient due to safety reasons. Dr. Donald Bliwise, at the Stanford University Clinical Research Center on Senile Dementia (MH40041), is studying the relationship of disturbed sleep, altered sleep-wake cycles, apneic episodes, daytime sleepiness and "Sundowning", or nighttime confusion, to excess disability in dementia patients. The prevalence of Sundowning will be assessed in both community dwelling and institutionalized demented patients through caregiver and nursing home staff reports. Preliminary data on sleep changes in dementia patients indicate that patients with normal oxygenation during sleep either showed less confusion in the morning, or were otherwise unchanged from the previous night, suggesting that increased confusion related to sleep oxygenation may represent an early phase of Sundowning. Studies of the clinical efficacy of several com-

monly used medications for Sundowning are also being undertaken (chloral hydrate, triazolam, thioridazine, 1-tryptophan).

RESEARCH ON THE EFFECTS OF AGE AND ACTIVITY RESTRICTION ON THE CIRCADIAN PACEMAKER

Mice exhibit sleep-wake circadian rhythms which deteriorate with age. Old, sedentary mice show profound fragmentation in the sleep-wake cycle due primarily to increased sleep during the normally active phase of the circadian day. Interestingly, young mice which are activity restricted show virtually identical diminutions in sleep-wake cycle consolidation. It is not known whether homeostatic attributes of sleep regulation change with age in this species. Researchers at Stanford University are investigating this question by continuously monitoring sleep-wakefulness in mice deprived of sleep during the active half of the day. Sleep deprivation significantly reduced nocturnal sleep in all mice regardless of age, and was particularly effective in aged mice. Unlike old mice, young mice exhibited progressively increasing tendencies to sleep despite the waking stimulus. However, there was no evidence of differences in diurnal sleep consolidation as a function of sleep deprivation or age. During the 12 hour rest phase (lights-on) following sleep deprivation, old and young mice showed identical levels of sleep that were indistinguishable from pre and post experimental baseline at corresponding times of day. Age-related differences in sleep manifestation during the sleep deprivation stimulus suggests that homeostatic processes underlying sleep drive may change with age. Surprisingly, diurnal sleep consolidation could not be improved as a function of enforced nocturnal waking. This may reflect a sleep ceiling effect delimited by intervening activity behaviors.

Other accomplishments over the last year in the human sleep and aging program at Stanford University include: (a) demonstration of an extraordinarily low prevalence of sleep complaints in a sample of carefully screened healthy 60 year old patients, thereby implying a relationship between the usual high prevalence of geriatric insomnia and declining physical health; (b) documentation that larger, but not shorter sleep times are associated with snoring in a representative sample of individuals 50-65 years of age, thereby suggesting that the original epidemiologic studies showing association between mortality and sleep times must examine other comorbid conditions insofar as short sleep times are concerned; (c) evidence that Multiple Sleep Latency Test (MSLT) defined daytime sleepiness in the elderly is relatively independent of neuropsychological test performance, thus implying that mental impairments seen in sleep apnea (see (d) and (e) below) are merely a function of impaired alertness; (d) mental impairment is related to sleep apnea in the aged independently from factors such as hypertension, alcohol use, and depression, known to be related to both; (e) over intervals of 5 to 10 years individuals showing the largest increases in sleep apnea are those individuals showing the greatest decline in mental test performance.

Researchers at Oakland University (Zepelin, MH42547) are examining the interrelationships among the normal deteriorative changes in sleep that occur over the human life span. Chief among these changes are the drastic diminution of slow wave activity in the encephalogram (EEG), the greater fragility of sleep (as measured by reaction to external stimuli), and sleep's consequent fragmentation. These could all stem from the effect of aging on a single regulator of sleep's intensity, or they could represent the confluence of parallel but independent aging effects. Another possibility is that one or more of these changes is related to metabolic rate, which declines with age in parallel with daily sleep time and slow wave activity in the EEG. Those possibilities are under study in males and females between the ages of 6 to 80 years. Thus far the research suggests steady and continuous deteriorative change in all the variables under study, by without close correlations between them. For example, decline in delta activity is not necessarily accompanied by equivalent decline in sensitivity to auditory stimulation during sleep, and vice versa. Change in at least two distinct sleep regulators seems to be involved. In quantitative terms, the most dramatic change in these regulators seems to take place between childhood and early adulthood, but in terms of the consequent subjective experience and discomfort, there is a gradual build-up during adulthood, reaching a climax in the later years.

Additionally, this research is examining the relevance of sustained wakefulness in the treatment of age-related disturbances in circadian timekeeping by studying the effects of scheduled sleep deprivation on free-running circadian rhythms.

STUDIES OF SUICIDE LATE IN LIFE

It has been well-documented that the elderly have the highest suicide rates of any age group. Cohort effects and demographic trends suggest that in the coming decades there will be vastly increasing numbers of late life suicides. These factors emphasize the need to better understand this phenomenon. Dr. Yeates Conwell (MH40381, MH00748, University of Rochester) has found that late life suicide is distinguished, by a number of demographic, behavioral, and psychopathologic differences, from suicide in other age groups and that these differences have implications for understanding brain-behavior relationships. Dr. Conwell found that the high suicide rates in late life are accounted for by especially high risks for males, with male to female ratios of up to 12:1 in the 85 and over age group, compared to 4:1 for the total population. In addition, with increasing age, suicide victims use more violent and lethal means to take their lives—the elderly have a much lower ratio of attempted to completed suicides. Psychological autopsy data show that the most common psychopathology of elderly suicides is an affective disorder of late onset; that it is less commonly associated with active substance abuse; and more often associated with physical illness or loss than in younger suicide victims. Dr. Conwell's continuing research is focusing on the development of a neurobiological model of late life suicide. Specifically, he is testing the hypothesis that late life suicide is a behavioral expression of neurobiological alterations in hypothalamic-pituitary-adrenal (HPA) axis dysfunction.

STRESS AND BURDEN: FAMILY CARE OF THE ELDERLY

Stress associated with family-based care of the elderly has significant social, emotional, and health consequences. Research on the primary caregiver, who is generally a spouse or daughter, has documented an array of psychological and emotional burdens. In studying the course of psychosocial needs of caregivers for AD patients, Dr. Dolores Gallagher of the Palo Alto Veterans Administration Medical Center (MH43407) found that 33 percent had a major affective disorder, and 21 percent met criteria for dysthymic disorder. The rate of anger was reported at 67 percent, with depressed mood identified in 54 percent of caregivers. A cluster analysis revealed that 50 percent of caregivers rated high on two out of three of the symptoms of dysphoria, anger and anxiety. These findings have lead Dr. Gallagher to develop two interventions: one aimed at anger management, and the second aimed at depression management. Dr. Gallagher will also assess how psychological stress, particularly an "anger-in" style may be correlated with cardiovascular disease. Repeated medical evaluations over a 1-year period will permit study of the interrelationships among caregiver psychological distress, physical health, and institutional placement of AD patients.

Indeed, there is evidence that the stress of caregiving is associated with health consequences. The Institute is currently funding several research projects that focus on the chronic impact of caregiving on immune functioning and psychological distress. One project being conducted by Drs. Janet Kiecolt-Glaser and Ronald Glaser at Ohio State University (MH42096) indicates that caregivers have increased rates of infectious illness and depression as well as deficits in immune functioning. From T1 to T2, caregivers who are no longer providing primary care become less depressed, however, the functional impairment to their immune system does not improve. How caregivers in different contexts—those caring for the patient in the home, those caring for a patient in an institution, those who institutionalized a patient during the course of the study, and those who are recently bereaved—may vary in immune function, is currently being explored.

Linking up with the findings by Dr. Gallagher reported above, one aspect of a recently funded study by Dr. Peter Vitaliano at the University of Washington (MH43267) is an examination of caregiver expression of anger and psychosocial, immunologic and cardiovascular distress. In another ongoing study, Dr. Igor Grant at the University of California, San Diego (42840), is investigating the impact of AD caregiving on adaptive health outcomes, as influenced by coping style, stress, support, and other person-environment factors. This research explores whether neuroendocrine measures and immunologic variables may help distinguish successful from unsuccessful caregivers, and may predict those who will themselves develop an illness.

Critical events in the role of caregiving have differential impacts on individuals. In a large prospective study, Dr. Leonard Pearlin at the University of California, San Francisco (MH42122), is striving to identify the range of stressors experienced by caregivers, and their access to and use of formal and informal supports. Drs. Powell Lawton, Rachel Pruchno, and Ms. Elaine Brody, all at the Philadelphia Geri-

atric Center (MH43371), are pursuing study of the variations in caregiving processes. The influence of intrafamilial dynamics, length of caregiving, and characteristics of the person and her social setting are being examined. Caregiving "careers" are being followed, both in new caregivers who will be studied past the death of their care-recipients, as well as in a specific subgroup of caregiving daughters of widowed, impaired older parents, in which the effects of daughter marital status will be assessed.

A number of researchers are systematically examining ways in which the care and management of Alzheimer's disease patients can be improved. Potentially, these improvements can lead to a reduction in caregiver stress, as well as contributing to improvements in the quality of life of the patient, and the reduction of patient "excess disabilities".

Since AD patients frequently manifest depression, psychosis and behavioral disturbances, a number of researchers are exploring better ways of documenting these problems as they develop effective treatments for these added disabilities. Dr. Davangere Devanand at Columbia University (MH44176) has developed a Behavioral Syndromes Scale (BSSD), and has found that some symptoms correspond to the illness course. Disinhibited behaviors and apathy—indifference increased with greater severity of dementia. Catastrophic reactions, aggression and agitation were associated with greater functional impairment, but not with the severity of cognitive deficits. Dr. Devanand has proposed that some of the behavioral changes in AD patients might be manifestations of underlying brain pathology separate from cognitive impairment. Moreover, many patients with psychosis and behavioral disturbances are currently treated with neuroleptic medications—the same antipsychotic treatment used with psychiatric patients who suffer from hallucinations and delusions. Addressing the inadequate data on the effects and safety of neuroleptic treatment in AD, Dr. Devanand is assessing the efficacy and side effects of low doses versus traditional doses of oral haloperidol for treating psychosis and behavior problems in AD patients. Specifically, Dr. Devanand is assessing somatic side effects, activities of daily living, and level of cognitive functioning as the result of administration of these two levels of haloperidol.

The added disability of depression in AD patients is the focus of a treatment study by Dr. Linda Teri of the University of Washington (MH43266). Dr. Teri has implemented a behavioral treatment for depression in AD patients by training their family caregivers in skills aimed at decreasing depression. One of the skills is to identify and engage the AD patient in suitable pleasant activities, thereby potentially improving patient mood, as well as the interpersonal relationship between the patient and caregiver. Interestingly, Dr. Teri has observed depression in over half of the caregivers of depressed AD patients at their entrance into the study, suggesting that the double burden of dealing with both AD and depression in the patient may put caregivers themselves at risk for depression. Preliminary results indicate that this caregiver-based behavioral treatment is effective for reducing depressive symptoms in AD patients.

In addition to studies seeking ways to reduce the excess disability of patients, the Institute supports several studies to test the effects of psychotherapeutic interventions on caregivers mental health. A study being conducted by Dr. Delores Gallagher-Thompson, described earlier, is designed to test the efficacy of anger and depression management as specific treatments. In another study, Dr. Steve Ferris at the NYU Medical Center (MH42216), is assessing the efficacy of a multicomponent individualized treatment approach which includes individual and family counseling and participation in an AD caregiver support group. Interim findings, reflecting short-term results, suggest that the treatment group, compared to the control group, had less severe deterioration to their mental and physical health, were less likely to institutionalize their AD patient, and were more satisfied with their social support networks. This study is continuing with an assessment of long-term caregiver outcome.

TREATMENT

Four areas of treatment research are pursued in the Institute: (1) basic psychopharmacology including age-related alterations in pharmacokinetics and drug metabolism; (2) clinical trials including acute, continuation, and maintenance treatments using pharmacologic, psychotherapeutic, and combined strategies; (3) analysis of side effects such as tardive dyskinesia, and cognitive and behavioral toxicity; (4) and modelling including the use of pharmacologic probes in order to characterize the underlying pathophysiology of disease. Examples of these areas are provided below.

Several investigators are studying a significant clinical issue that cuts across the treatment of several mental disorders of the aged—the high rate with which older

patients develop tardive dyskinesia (ED, or spontaneous movement disorders) as a side effect of treatment with neuroleptic medications. In a large prospective study by Dr. Dilip Jesse at the University of San Diego (MH45131), psychiatric patients over age 45 have shown a 30 percent incidence rate for newly developing TD (11 percent definite, 19 percent borderline) within 6 months of randomization to low-dose treatment with either haloperidol or thioridazine. Preliminary data for another prospective study by Dr. John Kane at Hillside Hospital/Long Island Jewish Medical Center (MH40015) reveal a comparable 31 percent TD incidence rate in patients age 55 and older studied naturalistically over 43 weeks of treatment with a broader array of neuroleptic medications. Both investigators are continuing further analyses of these surprisingly high rates in an attempt to disentangle the contributions of age, gender, diagnosis (e.g., dementia versus mood disorders or functional psychosis), medication dosage, and other variables, which tend to be highly confounded variables in the populations studied. Preliminary indications from the two projects have been inconsistent on the effects of diagnosis, but suggest that more specific factors such as instrumentally detected instability in motoric function or the early development of Parkinsonian signs may offer improved prediction of TD risk in elderly patients.

Depression in the elderly has been shown to be a chronic relapsing problem. The long-term prognosis for depression in late life is generally thought to be poor, with only one-quarter to one-third of patients showing a good outcome at 1-to-3 year follow-up.

Risk of recurrence increases with older age at first onset of illness, with a greater number of prior episodes, with a longer index episode, and with a shorter symptom-free interval. The Institute supports several ongoing treatment studies of the long-term treatment of depression in the elderly.

Dr. Alan Stoudemire's (Emory University, MH47597), research is directed towards elucidating three significant clinical issues in the long-term psychopharmacological treatment of depression in the elderly. Namely he is: (1) examining which pharmacotherapeutic strategies may be most effective in minimizing the high recurrence rates in geriatric depression; (2) assessing the effectiveness and comparative associated medical and neuropsychological side effects of the long-term use of either tricyclic antidepressants or lithium and; (3) is conducting a detailed exploration of what other classes of concurrently used medications, or types of co-existing medical illnesses common in this population, might contribute to depression and diminish the effectiveness of antidepressant therapies. Because pilot data revealed that elderly depressives with concomitant cognitive impairment appear to show the same response to psychopharmacologic treatment of depression, as well as the same risk for rate of relapse, as cognitively intact elderly depressives, this population has been included for study.

Over the past 7 years Dr. Charles Reynolds has conducted ground-breaking research in demonstrating the effects of pathological aging on brain function as expressed in sleep-wake organization. One of his major contributions has been to demonstrate that acute depression in late life is associated with profound and specific changes in the physiological organization and intensity of sleep, particularly in the first NREM-REM sleep cycle. He has hypothesized that these EEG sleep measures may be psychobiologic indicators of risk to recurrence in the depressed elderly undergoing long-term treatment. This hypothesis is currently being tested by Dr. Reynolds (Western Psychiatric Institute Clinic, University of Pittsburgh, MH37869, MH43832) within the framework of a large scale controlled study of maintenance pharmacotherapy (nortriptyline) and psychotherapy with respect to their prophylactic value in recurrent unipolar depression among 60-80 year olds. He recently reported a strong relationship between increase in REM latency and decrease in Hamilton depression ratings four weeks into continuation therapy. This is the first report of tricyclic antidepressant effects on EEG sleep in elderly depressed patients. Its theoretical importance pertains to the establishment of a relationship between sleep changes and antidepressant efficacy. Dr. Reynolds is continuing this research and will be contrasting patients who relapse during continuation therapy with those who remain well during continuation therapy. Dr. Reynolds hypothesizes that he will find greater residual abnormality in the sleep of patients who relapse, as compared to those who remain well.

It has been reported that up to 30 percent of geriatric patients treated with a tricyclic antidepressant, develop confusion or delirium, yet there have been no well-controlled studies assessing the effects of therapeutic blood levels of a tricyclic antidepressant to performance in the elderly. To examine this critical clinical issue, Dr. Nunzio Pomara (Nathan S. Kline Institute, MH44194), is currently examining the effects of nortriptyline on psychomotor and cognitive functioning in the elderly.

Nortriptyline (NT) is a tricyclic antidepressant with a well established therapeutic window and an absence of marked age-related differences in pharmacokinetics and a more favorable side effects profile. Using a placebo controlled, double blind, parallel group design, this study is comparing the performance of young and elderly depressed patients, in response to a single dose of NT, as well as chronic NT treatment at comparable therapeutic plasma levels.

Because of their widespread use, the acute and chronic effects of benzodiazepine on human performance are of considerable practical significance. Their effects on the elderly (aged 60 to 78 years) are of particular concern, since they may be more sensitive to some of the adverse central effects of the benzodiazepines. Moreover, normal age-related decline in cognitive functions may accentuate the significance of drug-induced deficits. Both animal model and clinical studies are addressing this critical concern.

The use of psychotropic drugs in the elderly, such as the benzodiazepines, is associated with substantial morbidity (due to falls and cognitive impairment), attributed to drug toxicity and interactions. Toxicity may occur, in part, due to enhanced sensitivity to drugs in the elderly. Although for several drugs sensitivity appears to be due to pharmacokinetic factors, for other drug classes, age-related kinetic changes are limited. Dr. Lawrence Miller (Tufts University MH47598), has hypothesized that since most psychotropic agents interact with neurotransmitter receptors, it is likely that enhanced sensitivity to psychotropic drugs, such as the benzodiazepines, is, at least in part, related to receptor interaction or post-receptor events. To elucidate receptor contribution to enhanced drug sensitivity Dr. Miller is examining the benzodiazepine/GABA system in aged mice. His initial data, while indicating no significant age-related alterations in binding or function at the GABA receptor complex in a mouse model, did reveal two potentially important neurochemical alterations in aged animals which may contribute to enhanced benzodiazepine sensitivity: (1) decreased benzodiazepine receptor synthetic rate in aged mice and (2) decreases in GABA receptor gene expression in aged mice. Based on these findings Dr. Miller is now examining, across a broad range of animal lifespan, the benzodiazepine receptor synthetic rate and GABA receptor gene expression in major brain regions. He is also examining the effects of chronic benzodiazepine administration on GABA receptor binding and function, and benzodiazepine administration on GABA receptor binding and function, and benzodiazepine receptor rate.

Clinical research on the acute and chronic effects of benzodiazepines on the performance of the elderly is also being supported by the Institute. Dr. Nunzio Pomara, in his initial research on the cognitive and behavioral side effects of the benzodiazepine, selected diazepam, which has a long elimination half-life, for study. He found that diazepam has remarkable cognitive toxicity after acute administration and prolonged effects after chronic bedtime administration. While it is often assumed that chronic treatment with benzodiazepine having shorter elimination half-lives (which results in less drug accumulation) will, in general, be associated with a smaller number of adverse effects on performance, there are few systematic studies of the effects of these drugs on performance in the elderly. In fact, there are even fewer studies which include the very elderly, who are the fastest growing segment of the aging population, and who may be particularly vulnerable to the adverse effects of benzodiazepine. Dr. Pomara (Nathan S. Kline Institute, MH42499), using the same general protocols as he did in his diazepam study, is now examining the cognitive and behavioral side effects of two short half life compounds, alprazolam and lorazepam. In addition, he will analyze the data within the elderly group to determine whether increasing age is associated with increased adverse effects on cognitive tasks.

Additional research being conducted by Dr. Richard Shader at Tufts University (MH34223, MERIT AWARD), is investigating the mechanisms and determinants of altered benzodiazepine sensitivity in the aging organism. Using both experimental and clinical models he and his colleagues are evaluating the aging-related consequences of chronic benzodiazepine exposure and chronic ethanol exposure, including assessment of the mechanisms of tolerance and rebound/withdrawal. These studies involve both normal volunteer human subjects and experimental animals. In humans, a range of outcomes is being assessed, including subjective measures (e.g., sedation, mood state), psychomotoric performance and information processing measures, and neurophysiologic measures (quantitative electroencephalography and topographic brain mapping). In the animal studies, outcome measures include both behavioral (computerized infrared monitoring) and neurochemical (e.g., receptor binding, number, affinity, function) analyses.

HUMAN MEMORY: STRUCTURE-FUNCTION RELATIONSHIPS

Memory is only poorly understood, despite its obvious importance to behavior. Studies of memory in humans are particularly difficult because it is often impossible to correlate functional performance with brain structure. For example, although patients with memory deficits can be given extensive testing, postmortem examination of the brain tissue from these same patients is often not feasible. Nevertheless, our understanding of human memory has been profoundly influenced by such structure-function correlations which have been made in a handful of cases. Thus, the ability to test the memory performance of patients with known brain structure abnormalities would herald a new understanding of the neuroscience of human memory. In research supported by the Institute, this new understanding of human memory is emerging from studies carried out by Dr. David Amaral of the Salk Institute in California (R37 MH41479). Dr. Amaral and his colleagues have combined memory performance testing with state-of-the-art noninvasive brain imaging techniques to study the detailed brain structure of patients with memory problems. This research revealed that a region near the middle of the brain (the mammillary bodies) was much smaller in one group of amnesic patients compared to control subjects with no memory deficit; lateral brain structures (including the hippocampus) appeared normal. In contrast, in a second group of amnesic patients (not clinically distinguishable from the first group), the mammillary bodies were of nearly normal size, but the hippocampus was much smaller than normal. In addition to correlating abnormalities of either of two very different brain regions with memory deficits, this powerful approach broadly sets the stage for novel research directions in many areas of human neuroscience.

Scientists at the University of Illinois (MH35321) have shown that environmental enrichment can not only make an organism "smarter" but many make the brain less vulnerable to damage later in life.

Rats reared in enriched surrounding have long been known to be "smarter," in terms of the ability to learn complicated tasks such as mazes, than standard laboratory rats. Dr. William Greenough and his colleagues have found that rats raised in enriched surroundings form more synaptic connections between neurons, which changes the functional "writing diagram" of a number of brain regions. This enhanced synapse formation is not restricted to a particular critical developmental period. Young adult and middle-aged rats exhibit a robust synaptogenesis when placed in a complex environment while older rats show much less pronounced responses.

More recently these scientists have found that young rats placed in an enriched environment nearly double the number of capillaries in the visual cortex within about 4 weeks. In young adult rats, while there is some responsiveness, capillary proliferation is very much diminished, and it is essentially gone by "middle age." This suggests that an important component of early human brain development—one that has received almost no attention to date—is the development of the ability to "power" the brain's neurons and their synapses, with the oxygen and nutrients supplied by the vascular system. This opens the possibility that this early preparation may also be related to later vulnerability to vascular dysfunction such as stroke. Additional experiments, have shown that the ability to add blood vessels in adult life may be increased, in some areas of the brain, by exercise.

Thus, from this research, a picture is emerging of some the requirements for a "healthy brain" throughout life. Early in middle age and later, physical exercise emerges as an additional critical factor.

MEMORY AS AFFECTED BY DISEASE, INJURY, AND AGING

Research at the Veteran's Affairs Medical Center and the University of California-San Diego (Squire, MH24600) is directed toward understanding the organization and neurological foundations of human memory. The work especially focuses on the analysis of memory dysfunction in carefully selected patients with neurological injury or disease which may also related to changes that occur in normal aging and Alzheimer's disease. The 12 projects include studies to resolve whether or not amnesia disproportionately impairs spatial memory; studies to resolve whether or not amnesia disproportionately impairs recall compared to recognition memory; studies of source amnesia; studies of the ability of amnesia patients and frontal patients to learn about temporal order; studies of skill learning, central tendency effects, immediate memory, biasing effects in perception, and word priming; studies of retrograde amnesia; and a PET scan study of memory. These studies address fundamental questions about how memory is organized in the brain and the changes due to disease, injury, and aging.

MEMORY RECALL LINKED TO ACTIVATION SPREAD OF ASSOCIATIVE NETWORKS

Memory failures and inefficiencies are a source of anxiety as people approach senior years and in many cases the memory deficiencies are deleterious to general mental functioning. The problem of memory acuity is both widespread and progressive. While the concept of cognitive aging has been established by the negative relationship between age and cognition, not much progress has been made in explaining cognitive aging phenomena. Recent cognitive research (McEvoy, MH45207) at the University of South Florida has made an important advance in explaining problems of memory retrieval among elderly persons. One recent finding suggests that retrieval of information is inefficient because both the *size* and *interconnectedness* of the memory network decrease as people age. Using a measure of connectivity to indicate shared association and shared meaning among words and concept, McEvoy has found that even when elderly people possess proper associations of meaning for words and concepts, there is not a collateral interrelatedness or connectivity among the concepts. Normally, for highly interconnect concepts, activation can accrue to the memory target and its associates both directly and indirectly, whereas for a concept with low connectivity activation is primarily direct and through a single pathway. These effects are most pronounced when contrasting explicit and implicit memory. Elderly people show reduced network size especially with respect to implicit memory representations. The issues, then, is not that elderly people do not have a lot of memories, but that retrieval of information they possess is inefficient because the activation spread during the process of memory access is reduced.

NEUROPEPTIDE IMPLICATED IN AGE-RELATED COGNITIVE IMPAIRMENT

An NIMH supported researcher at the University of North Carolina, Chapel Hill, has made a unique discovery that aged rats with spatial learning deficits differ from both young rats and their unimpaired aged cohorts in exhibiting elevated opioid (dynorphin) peptide content as well as gene expression (prodynorphin mRNA) in the hippocampus and frontal cortex of the brain. Current research in this laboratory is examining the brain systems responsible for these neurobiological changes in aged animals with identified cognitive impairment. These studies are relevant to understanding the functional interrelationships among various hippocampal parameters that distinguish the learning/memory ability of aged animals. Such an understanding is important for developing either therapeutic strategies to treat age-related cognitive impairments or interventions aimed at decelerating the aging process itself.

AGE-RELATED CHANGES IN CHOLINE METABOLISM IN NEURONS: EFFECT OF POTASSIUM CHANNEL BLOCKERS

Dr. Wurtman's laboratory at MIT has shown that the potassium channel blocker 3,4-diaminopyridine (3,4-DAP) increases acetylcholine (ACh) release from rat brain (striatal) slices while protecting against the membrane phospholipid depletion induced by electrical stimulation. Several lines of evidence indicate that there is an age-related cholinergic deficit which may be responsible for reductions in memory function. This led the researchers at MIT to examine both presynaptic and postsynaptic indices of cholinergic activity in young and aged rats, and to examine the effects of aminopyridines on these parameters. Basal ACh release did not differ between superfused striatal slice preparations from young and aged rats. However, electrically evoked ACh release was greater in young rats. Addition of 3, 4-DAP to the superfusion medium resulted in increased ACh release from slices from both young and old animals. Carbacholstimulated phosphatidylinositol turnover in striatal brain slices was similar in both groups of animals, suggesting that age-related deficits in central cholinergic transmission may derive from an impairment in evoked ACh release. This laboratory is currently examining the effect of electrical stimulation on the phospholipid composition of brain slices from young and old rats, to determine if aging enhances the susceptibility of neurons to activity-related reductions in phospholipids, the effects of stimulation on levels of various choline-containing metabolites (phosphocholine, CDP-choline, and glycerophosphocholine) will be measured, and the efficacy of various potassium channel blockers in maintaining ACh release and preventing the phospholipid depletion is being explored.

Social Regulation of Aging

Group social interactions may alter physiological processes and ultimately affect such things as the aging process, as reflected by how long the female is capable of reproduction. Martha McClintock's continuing research at the University of Chicago (MH41788) investigates the effects of the social group upon estrus synchrony and

the consequences of such synchrony or asynchrony. McClintock has found that females living in groups, as compared to isolated females, were capable of reproduction significantly longer. This research has identified a biomarker for vulnerability to the social isolation and to premature reproductive aging. The result speaks to the influences of the group upon physiological functioning and the vulnerabilities of certain members of the group, namely the females.

Personality Development in Women from College to Midlife

In a unique longitudinal study of women's personality development (MH43948), Ravenna Helson at the University of California, Berkeley, has followed a group of women from their college graduation at 21 years of age to their early fifties. Her wide-ranging methods have included assessments of personality, as well as significant aspects of work, personal relationships, and quality of life. In her longitudinal exploration of these processes, Helson has emphasized the themes of psychological health and normative personality change in the context of career and family roles. While this work has focused on a rather homogeneous group of women, other researchers are beginning to explore similar issues in differing socioeconomic groups. Most recently, Helson's work has addressed whether women have a prime of life. While cultural stereotypes have suggested that women peak in late adolescence, when their fertility is at its apex, Helson concludes that women rate their lives as most satisfying in the post-parental period when they reach their early fifties. For Helson, the concept of the prime of life offers a "linguistic umbrella" under which researchers can look for achievements of intrapsychic and interpersonal goals by older women as well as for problems that thwart the attainment of these goals.

Basic Brain Function and Development

To approach the question of how abnormal gene expression affects brain development and function, this neuroscience group at Johns Hopkins School of Medicine (Coyle, MH46529) is concentrating on the neurobiologic consequences of gene imbalance of mouse chromosome 16. There is considerable homology between this mouse chromosome and human chromosome 21. Down's Syndrome results from triplication of the far end of human chromosome 21, and it is the most common identified genetic cause of mental retardation, is associated with a high risk of affective disorder, and invariably results in the pathology of Alzheimer's disease by the fourth decade. Mice with trisomy 16 exhibit many of the characteristics of Down's Syndrome, including altered expression of amyloid precursor protein, and accumulation of the A4 amyloid peptide in neuritic plaques and neurofibrillary tangles. This group is examining transgenic mice for an extra copy of specific genes on chromosome 16, including a study of the genetic mechanisms regulating the developmental expression of amyloid precursor protein, in order to understand the basis of the connection between Down's Syndrome and Alzheimer's Disease. Transplant studies and primary cultures of fetal brain cells from normal versus trisomic mice seek to identify genes that may impair basal forebrain cholinergic development, alter somatostatin expression, and increase neuron sensitivity to oxidative stress in trisomic mice. Trisomy 16 mice and new transgenic lines will be screened for neurochemical and behavioral activity, as well as their capacity for learning and memory.

Grants to Mauricio Montal, University of California, San Diego (MH44638 and MH00778) support work on the structure and function of channel proteins. The techniques involved encompass membrane biophysics, molecular biology and protein engineering. Using information about the primary structure of several channels, gained from the cloning of the genes, the investigator has derived a theoretically derived model of their secondary structure. For the calcium channel they have then made synthetic, oligopeptide, four-stranded model compounds that should function as the "pore" and voltage sensor of the transmembrane channel. The function of the model compounds, and the effects of synthetic "mutant" peptides is tested using synthetic membranes where the electrical and pharmacological properties are measured. These techniques should provide a fundamental knowledge of the determinants of channel properties and provide a new model for the screening and investigation of drugs that could affect channels.

George Siggins at the Scripps Research Foundation (MH44346) is responsible for the discovery that somatostatin, an important peptide neurotransmitter, through its effects on potassium conductance, potentiates the excitatory effects of acetylcholine on hippocampal pyramidal cells. Using slice preparations of rat hippocampus and cortex, he will characterize the mechanism of action of somatostatin and its interactions with other neurotransmitters. Current results indicate that the somatostatin effect on the potassium current is mediated by a metabolite of arachidonic acid,

whereas the acetylcholine effect on the same potassium current is mediated by inositol triphosphate. This is the first demonstration in the vertebrate CNS of these two different second messengers regulating the actions of opposing receptors on a single ion channel type. The investigators are also using new methods to perform whole-cell patch recording in identified cells of slice preparations. In preparations, such as the hippocampus, where preservation of determined anatomical connections is essential for studies of models of learning and memory, these techniques will enable studies of individual cells without resort to dissociated cultures. These cellular neurobiologic studies should provide needed basic information on signalling properties of somatostatins and their functional roles in the CNS. Since Alzheimer's Disease is associated with a dramatic reduction of ACh, somatostatin and somatostatin receptors, and characterized by severe loss of memory, these fundamental studies are relevant to consideration of the therapeutic use of synthetic somatostatin peptide agonists or antagonist in clinical disease states such as dementia.

NURSING HOME STUDIES

Researchers at the Institute-supported Mental Health Research Center, Madison, WI, found that elderly residents in facilities with less adequate staffing and other resources were significantly more likely to have a tranquilizer order, to have a tranquilizer administered, and to have any deviation from drug use criteria. Based on data from a 1-month active medication file for 760 elderly residents in seven skilled nursing homes in Wisconsin, the researchers noted that a comparison of tranquilizer practices in the homes with specific drug use criteria showed that nearly 19 percent of all elderly residents were exposed to some type of excess use such as long duration, polymedicine, or therapeutic duplication. The analysis, directed by Dr. Bonnie L. Svarstad and one of the first nursing home studies in which tranquilizer use has been compared to specific drug use criteria, noted that "... our findings raise serious concerns about the frequency and quality of tranquilizer use in this vulnerable population." A related study at the Center, directed by Dr. David McKee, explored the question of whether for-profit facility ownership has an effect on the quality of antipsychotic medication use among nursing home residents. Data obtained from a sample of 216 residents in the same homes used in the Svarstad study found no relationship between for-profit facility ownership and deviations of excess antipsychotic use, either by itself or when controlling for the effects of resident characteristics.

A study of the impact of the first year of implementation of nursing home reform provisions under the Omnibus Budget Reconciliation Act of 1987 conducted in Connecticut found there were no significant changes in the numbers of Medicaid recipients pre- and post-OBRA 1987 and in practices with regard to psychotropic medication used in care of this population. The research, directed by Dr. Linda Frisman at Yale University with colleagues at the University of Connecticut, was based on a random sample of 5,089 cases for the years 1988 and 1989 from 104 Intermediate Care Facilities and 202 Skilled Nursing Facilities. The mean age of Medicaid patients in both years was approximately 81 years with three-quarters of the patients being women, almost half of this population age 65 to 84. While there were initial concerns in the States that the screening, admission and continued stay review procedures under OBRA 1987 might reduce the supply of beds to psychiatric patients, this fear was not borne out in this study of the Connecticut Medicaid experience, according to the researchers. The study noted "given the very small percent of persons who are functionally independent and who also have been resident in nursing homes for less than 30 months, it is unlikely that OBRA will cause a major displacement of nursing home residents." The researchers conclude that the impact of OBRA is more likely to be found in the type of care received in the nursing home.

PROSPECTIVE PAYMENT AND MENTAL HEALTH SERVICES

An analysis of Medicare cost data for the period 1984-89 shows that Medicare reimbursement for psychiatric hospitals reimbursed under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 has become increasingly stringent, with an ever-growing proportion of such providers failing to meet the cost target set for them by the Health Care Financing Administration. This was one of the findings from an Institute-supported grant directed by Dr. Howard P. Tuckman and Dr. Cyril F. Chang of Memphis State University that examined the profitability of treatment of Medicare patients for psychiatric hospitals exempted from the Medicare Prospective Payment System (PPS) and reimbursed under the TEFRA payment system. The findings were reported as one of three presentations made by NIMH grantees as a panel entitled "The Effects of Prospective Payment on Psychiatric Hospitals" at the

66th annual Western Economic Association International Conference in Seattle, WA, June 23-29, 1991. Drs. Magbool Dada, William D. White and Houston H. Stokes of the University of Illinois, Chicago, presented preliminary findings from their research indicating there would be substantial differential financial risk associated with implementing a unified PPS for exempt psychiatric services under current Medicare payment rules; the research is examining a number of payment options that might be considered in mediating financial risk for such services if they are included in the current PPS system. In a third presentation, using Medicare data, Dr. Carol Siegel of the Nathan S. Kline Institute for Psychiatric Research of the New York State Office of Mental Health reported on preliminary results of research being directed by her indicating that a payment system blending patient, hospital and national costs promotes greater access to care and is more equitable to psychiatric providers than a prospective payment system based solely on national average costs.

PROGRAM DEVELOPMENT—INITIATIVES FOR FY 1992

A number of specific initiatives are planned for FY 92. These include:

- Follow-up to the Consensus Development Conference on Diagnosis and Treatment of Depression in Late Life.
- A workshop on the methodology of clinical research with special reference to suicide in the elderly.
- A workshop on new approaches to the application of functional brain imaging techniques in late life mental disorders.
- Development of the NIMH-Academic-Industry collaborative workgroup on geriatric psychopharmacology.
- A series of special activities including development of special fact sheets for use in the 1993 White House Conference on Aging.

In addition, a number of ongoing initiatives in Alzheimer's Disease and other mental disorders in late life will be pursued. These will be summarized in an Institutewide Omnibus Program Announcement for Research on Mental Disorders of the Elderly which is planned for publication in FY 1992.

EVALUATION OF MEDICARE COVERAGE CHANGES

NIMH will collaborate with the Office of the Assistant Secretary for Planning and Evaluation (ASPE), DHHS, in providing funding and technical assistance to an ASPE-awarded task order to Lewin/ICF, Washington, D.C., that is developing a research design to evaluate recent changes in Medicare coverage of outpatient mental health services.

FINANCING OF MENTAL HEALTH SERVICES

Research grant applications will be encouraged that examine financing issues that facilitate implementation of the recommendations of the report entitled *Caring for People with Severe Mental Disorders: A National Plan of Research to Improve Services*.

ITEM 7. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

JANUARY 24, 1992.

DEAR MR. CHAIRMAN: This is in response to your October 2, 1991, request that the Department of Housing and Urban Development's report for inclusion in Developments on Aging be submitted to the Special Committee on Aging.

Enclosed is the requested material. I hope that our information will serve as a useful reference document.

Any questions regarding this response may be directed to Russell K. Paul, Assistant Secretary for Congressional and Intergovernmental Relations at 202-708-0005.

Very sincerely yours,

JACK KEMP,
Secretary.

Enclosure.

U.S. HOUSING FOR THE ELDERLY—FISCAL YEAR 1991

The Department of Housing and Urban Development is committed to providing America's elderly with decent affordable housing appropriate to their needs. The elderly, who are the fastest-growing segment of our Nation's population, are often frail and in need of supportive services to help them stay in their homes and avoid

institutionalization. The Department's goal is to provide a variety of approaches so that older Americans may be able to maintain their independence, remain as part of the community, have access to supportive services, and live their lives with dignity and grace. Accordingly, the Department has sought to expand its ability to link housing and appropriate services for the elderly.

The Administration proposed and Congress adopted as part of the National Affordable Housing Act of 1990, the "HOPE for Elderly Independence" initiative, which is designed to test the effectiveness of combining rental voucher and supportive services assistance to enable frail elderly individuals to continue to live independently. For many of these individuals, who are faced with increasing infirmity, or recovering from an illness or injury, the only choice is to enter a nursing home to receive supportive services. Such supportive services are very costly in a nursing home situation and may be much more intensive than needed. However, there are few other alternatives.

Until 1990, HUD's only program which provides both housing and supportive services assistance was the project-based Congregate Housing Services Program (CHSP). That program provided funding for supportive services in elderly public housing and Section 202 projects. Thus, the services provided were only available to those individuals who lived in the 58 projects approved to participate in CHSP, or people willing to move into those projects.

HOPE for Elderly Independence will allow frail elderly individuals more choice in determining where they want to live, since supportive services will not be limited to specific projects or units. They will even be able to remain in their present units, as long as their units meet the Section 8 Housing Quality Standards. The public housing agency (PHA) (or Indian Housing Authority (IHA)) would be authorized, however, to require individuals to live in a specific geographic area, if that is necessary, to make the provision of supportive services feasible.

Unlike CHSP, which provided "gap" funding of supportive services, this demonstration will only require HUD to provide 40 percent of the supportive services funding. This reduction in the percentage of HUD's funding responsibilities is designed to correct a problem found in CHSP—payments for unnecessary services.

Funding for supportive services is available from many State and local sources, but coordination of these resources and the targeting of them to very low-income frail elderly individuals has been difficult. By requiring applicants to secure at least 50 percent of the services funding needed from other sources, HUD will be using its funding to leverage these other funding sources. In addition, by requiring that at least 10 percent of the funding be from the elderly participants themselves, HUD hopes to minimize the use of unnecessary services.

This demonstration will provide housing assistance and supportive services for a five-year period. It will require that frail elderly individuals receive both housing assistance and services, rather than simply making supplementary supportive services available on an optional basis to those individuals currently receiving housing assistance. Services which can be funded include assistance with bathing, dressing, meals, and mobility, case management, counseling, supervision, and other services essential to achieving and maintaining independent living. The demonstration will require that the program be targeted to those frail elderly individuals with deficiencies in at least three activities of daily living who need this assistance in order to live independently and that the services provided be tailored to each individual's needs. Guidelines for this demonstration were published in the Federal Register on February 4, 1991 and it is anticipated that the Notice of Fund Availability (NOFA) will be published in April 1992, with applications due at the end of May.

Awarding of funds for supportive services and housing vouchers under the demonstration will be made through a national competition; awards will be announced by the end of July, 1992. An evaluation of the effectiveness of the demonstration in enabling frail elderly individuals to live independently will be an integral part of the demonstration.

Administration of HOPE for Elderly Independence was transferred from the Office of Housing to the Office of Public and Indian Housing and the end of Fiscal Year 1991.

In addition to the HOPE for Elderly Independence initiative, the Department administers a variety of other programs, described in this report, which provide useful and helpful opportunities for low and very low-income elderly people.

I. HOUSING

A. SECTION 202—DIRECT LOANS FOR HOUSING FOR THE ELDERLY OR HANDICAPPED

The Section 202 Direct Loan Program has been the Department's primary program for providing housing for the elderly. It provided direct Federal loans to private, nonprofit corporations to finance the construction or substantial rehabilitation of residential projects and related facilities to serve the elderly or handicapped.

The Section 202 program was enacted by the Housing Act of 1959. Originally, the program was intended to serve persons whose incomes were above public housing eligibility levels, but still insufficient to obtain adequate housing on the private market. The Housing and Community Development Act of 1974 amended Section 202 to permit the use of Section 8 housing assistance payments for eligible lower-income persons who live in projects financed under the program. These payments made up the difference between the rent established for the unit and the tenant contribution, i.e., 30 percent of adjusted gross income.

Section 162 of the Housing and Community Development Act of 1987 further amended Section 202 to ensure that the program met the special housing and related needs of nonelderly handicapped families and individuals. Beginning in Fiscal Year 1989, projects for people with handicaps were assisted by project assistance payments. Rents were not to be determined on the basis of Fair Market Rents, but were determined by the reasonable and necessary costs of operating a project for people with handicaps. Rental assistance for Section 202 projects for the elderly was not changed.

During Fiscal Year 1990, the Department committed \$283 million to finance 5,110 rental housing units for the low-income elderly and \$102 million for 2,193 rental units for low-income persons with handicaps.

Loans under the program covered up to 100 percent of total development cost and are to be repaid over a 40-year period at below-market interest rates. During Fiscal Year 1990, the interest rate was 8½ percent. For Fiscal Year 1991, the annual interest rate is 9 percent.

From reactivation of the Section 202 program in Fiscal Year 1974 through Fiscal Year 1990, approximately \$10.3 billion has been reserved, representing 4,936 projects and 226,916 units. Due to the Department's outreach efforts, minority sponsors were awarded over 16.8 percent of the total funding in Fiscal Year 1990.

When this Administration took office, the backlog of Section 202 units that had been funded but remained, sometimes for years in the construction pipeline, was unacceptably high. The Department has undertaken an aggressive program to eliminate the backlog, and during the period of December 1989 through November 1990, approximately 12,000 Section 202 units reached the start of construction. Additionally, more than 10,700 units began construction in Fiscal Year 1991.

The National Affordable Housing Act authorized a restructured Section 202 program, under which funding would be provided through a combination of interest-free capital advances and project rental assistance. Development costs would be based on per unit cost limits adjusted by local high cost factors, rather than being limited as in many cases by fair market rents, which have created serious delays in the current program. These changes were implemented in Fiscal year 1991. A Notice of Fund Availability (NOFA) was published June 12, 1991 and approvals are expected to be announced by February 28, 1992.

Although sufficient Section 202 funds were appropriated to fund almost 9,400 units, available project rental assistance would fund only about 6,400 units.

B. 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 rental accommodations for persons aged 62 years or older, married or single.

Section 231 is designed solely for unsubsidized rental housing for the elderly. Non-profit as well as profit-motivated sponsors are eligible under the program. At the end of Fiscal Year 1991, 502 projects, providing 66,697 units for elderly families, have been insured under the program. Total insurance written was \$1,172,835,635.

C. 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 rehabilitation of rental or cooperative structures. Projects insured under Section 221 can be designed for occupancy exclusively by the elderly,

although many projects have also been developed for families, most of whom are not elderly. The programs are available to nonprofit and profit-motivated mortgages as alternatives to the Section 231 program, which has largely been replaced by these sections for construction of housing for the elderly.

From the beginning of the 221(d)(3) and (4) programs through Fiscal Year 1991, 11,384 projects containing 1,256,027 units were insured, for a total of \$32,227,406,250. Residents in 485,677 of the units were receiving Section 8 rental assistance.

D. SECTION 223 (F)—MORTGAGE INSURANCE FOR THE ACQUISITION OR REFINANCING OF EXISTING MULTIFAMILY HOUSING PROJECTS

This program offers mortgage insurance for existing facilities, including cooperative and rental housing for the elderly, where repair needs do not warrant substantial rehabilitation. The program can be used either in connection with the purchase of a project or for refinancing only.

E. SECTION 232—MORTGAGE INSURANCE FOR NURSING HOMES, INTERMEDIATE CARE FACILITIES, AND BOARD AND CARE HOMES

The primary object of the Section 232 program is to assist and promote the construction and rehabilitation of nursing homes and intermediate care facilities. The vast majority of the residents of such facilities are elderly. Since the beginning of the program in 1959 through September 1991, the Department has insured 1,783 facilities, providing 213,735 beds, for a total of \$4,040,211,514.

The Housing and Urban-Rural Recovery Act (HURRA) of 1983 established a Board and Care Home program for the elderly and others as part of Section 232. The program permits units with shared bedrooms and bath facilities and central kitchens. These facilities provide continuous protective oversight of the residents. There is no medical component and no Federal requirement for a certificate of need. Board and Care Homes must meet State and local licensing and occupancy requirements.

F. SECTION 236—MORTGAGE INTEREST REDUCTION PAYMENTS

Section 236 of the National Housing Act has assisted private owners to build and operate rental housing wholly or partially for the elderly. The program provides mortgage interest reduction payments to owners, thereby reducing tenant rents. No new mortgages can be insured under this program. Section 236 projects may include self-contained apartments, congregate facilities or a combination of the two. Projects may contain cafeterias or dining halls, community room, workshop, health care services and other essential services. Eligible lower-income tenants in many Section 236 projects receive other forms of rental assistance, including Section 8 housing assistance payments.

G. SERVICE COORDINATORS IN SECTION 202 PROJECTS

The National Affordable Housing Act established service coordinators as an eligible expense under the Section 202 program. Service coordinators are a critical component of the management team whose function is to assist the frail residents of a project access supportive services that they need from the general community.

In Fiscal Year 1991, utilization of service coordinators was limited to those projects in which a majority of the residents were frail; no more than one coordinator can be hired per project. HUD issued a program Notice implementing the service coordinator effort in May 1991.

H. THE CONGREGATE HOUSING SERVICES PROGRAM

The Congregate Housing Services Program (CHSP) was designed to demonstrate the cost-effectiveness of providing supportive services for the elderly and people with disabilities under HUD auspices to prevent or delay unnecessary institutionalization. Under this program HUD made multiyear grants to eligible public housing agencies and nonprofit Section 202 owners for meals and other supportive services needed by frail elderly and nonelderly disabled persons. The CHSP was converted to an ongoing program in 1987.

In Fiscal Year 1991, 58 grantees are operating, serving approximately 1,800 residents on a regular basis. Additionally, about 150 residents were served last year on a short-term, temporary basis, usually after incapacitation or hospitalization. Congress appropriated \$9.5 million in Fiscal Year 1991. Six million of these funds were used to extend the 58 grantees for one additional year, with the remainder put aside

for use with the Fiscal Year 1992 extensions. Renewals are processed consistent with the expiration date of the grantees.

The National Affordable Housing Act established a revised CHSP, which parallels the HOPE for Elderly Independence program. In the revised CHSP, the major changes are as follows:

1. Eligible applicants have been expanded from public housing and non-profit sponsors under Section 202 to include Sections 221(d), 236, Section 8 Project-based, and Sections 514, 515 and 516 under the Farmers Home Administration. States, Indian tribes and units of general local government can also apply on behalf of eligible owners regardless of whether the project ownership is non-profit or for-profit.
2. CHSP has been converted from a HUD-funded effort to one in which HUD pays only 40 percent of the cost of the services, the grantees or third parties pay 50 percent and the participants pay 10 percent. Thus HUD funds become leverage for gaining needed dollars from other sources.
3. A service coordinator is now mandated to work together with the professional assessment committee.
4. Eligible services have been expanded to include monitoring of medication consistent with state law, home safety assessments and purchase of personal emergency response systems.
5. Retrofit and renovation are now eligible expenses under the CHSP.

HUD developed interim regulations during Fiscal Year 1991; these should be published during Fiscal Year 1992.

The existing 58 grantees are completing the first year of a 3-year transition to the revised CHSP. Program requirements necessary to implement the revised statute will be put in place during the transition period, except for the match requirement, which will be implemented in 1994.

I. 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.

J. HOME EQUITY CONVERSION MORTGAGE INSURANCE DEMONSTRATION

The Department has implemented a program to insure Home Equity Conversion Mortgages (HECM's), also known as "reverse mortgages." The program is designed for persons aged 62 years or older. Under the Housing and Community Development Act of 1987, the Department was authorized to insure 2,500 reverse mortgages. Reservations of insurance authority were allocated among the ten HUD Regions in proportion to each Region's share of the Nation's elderly homeowners. In February 1989, the Regional Officers of Housing held random drawings. A total of 50 lenders were selected; each received 50 reservations. In late 1990 the Omnibus Budget Reconciliation Act (OBRA) of 1990 increased the statutory authority to 25,000 mortgages and extended the termination date of the demonstration to September 30, 1995. Accordingly, the lender allocation and reservation procedure is being terminated and any FHA-approved lender may participate in this program without restrictions.

Reverse mortgages allow borrowers to convert the equity in their homes into a monthly stream of income or a line of credit. A borrower may choose from among four basic payment options: (1) tenure—provides a borrower fixed monthly payments for as long as the borrower continues to live in his or her home as the principal residence; (2) term—provides fixed monthly payments for a period of months selected by the borrower; (3) line of credit—permits the borrower to make draws up to a maximum amount at times and in amounts of his or her choosing; (4) tenure or term combined with a line of credit. A borrower is never required to pay back the loan as long as he or she is living in the property as his or her principal residence. If the borrower moves or dies and the property is sold, HUD will insure lenders against losses that could occur if the proceeds from the sale of the property are not sufficient to pay off the mortgage balance.

To date, almost 2,000 cases are either in progress or have been endorsed. The heaviest concentration of use has been in the Northeast and mid-Atlantic regions. An interim report on the program was sent to Congress on October 1, 1990. A second report to Congress containing a preliminary evaluation of the demonstration is currently being prepared, and is due on March 30, 1992.

II. PUBLIC AND INDIAN HOUSING

The Low-Income Public Housing program is today the largest single government-sponsored source for housing for the elderly in the United States. According to a special survey of occupancy reporting data as of September 30, 1991, public housing agencies were managing an inventory of slightly over 1.3 million units of which 343,910 were occupied by families in which at least one of the principal householders was aged 62 or more. This amounts to approximately 28 percent of all occupied units.

(There are some higher estimates of "elderly" population in public housing, but this number is subject to distortion by the fact that, according to statutory definitions, "elderly families" include families in which the head-of-household or his or her spouse is handicapped or disabled, irrespective of age. Under this statutory definition, it is estimated that about 40 percent of the population in PHA-owned housing is "elderly".)

Public housing developments are almost always owned by a Public Housing Authority (PHA), but specific programs provide for PHAs' lease and operation of privately-owned buildings or projects. Most PHAs, and many Indian Housing Authorities, also operate Section 8 housing assistance payments programs.

In the Public Housing program, the Federal Government—through the local PHA—pays for development costs and provides operating subsidies to ensure that low rents and adequate services are available. In addition, modernization funds are provided to PHAs to enable them to rehabilitate older projects. As a condition for this assistance, the PHA agrees to use and maintain the property as decent, safe, and sanitary housing for eligible lower income people, consistent with the requirements of Federal law and regulations. Rents, including utilities, have been set by Congress at 30 percent of adjusted tenant income. In calculating adjusted income, some special deductions are made in the case of the elderly.

In many public housing projects, special facilities and services are provided to meet the needs of the elderly, such as safety and security features, meals and transportation services, and recreational programs. These special services are usually provided by other agencies that rely on funding from Federal, State, and private sources, with the PHA supplying the facilities and acting as the local coordinator.

As a result of statutory amendments in 1983 and 1984, this Department and the PHAs are directed to give priority to applications for new developments for families requiring three-bedroom and larger rental units. In addition, because new public housing development is not the most cost effective means of increasing the availability of affordable housing, production of new public housing is no longer the principal vehicle for development of additional housing resources for lower income elderly and handicapped people under Federal housing programs. In 1991, the Department reserved funding for 8401 new units of which only 282 were identified as being for elderly persons or families. The primary emphasis in public housing for the elderly has become preservation of existing stock, maintenance and restoration of existing facilities, and expansion of non-housing services for an aging population.

Other programs, such as the Section 202 direct loan program for development and the Section 8 certificate and voucher programs for rental assistance in privately owned buildings, account for the bulk of new units added to the inventory of housing for the elderly in recent years. Because of their design features, those programs as well-suited to meeting the specific needs of the elderly.

In general, public housing projects have been successful in meeting the needs of their elderly and handicapped residents. Standards of design and maintenance have been high, along with resident satisfaction. PHAs report that elderly residents are excellent tenants and citizens, who take pride in their homes and play important roles in management and service programs.

A. SECTION 8—RENTAL CERTIFICATES AND RENTAL VOUCHERS

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 Section 8 Existing housing program, rental assistance is provided for families in a variety of existing housing through the use of rental certificates and rental vouchers. Under these programs, assisted families pay 30 percent of adjusted income toward rent and public housing agencies (PHAs) funded by HUD pay the difference between the tenant contribution and the market rent for suitable units that meet program requirements.

The Section 8 rental certificate program has proved particularly helpful to "elderly families", because many such residents have been able to qualify for housing as-

sistance while remaining in place, that is, without having to move into an assisted project. Units leased "in place" this way are required to meet HUD's Housing Quality Standards (HQS). As of September 30, 1991, there were approximately 1,000,000 units reserved under the Certificate program.

Rental Vouchers, which also enable families to receive assistance without moving, are believed to be even more beneficial to elderly persons because, unlike the rental certificate program, the absence of rent ceilings allows the family a greater choice in choosing an eligible unit. Cumulatively through Fiscal Year 1991, approximately 280,000 rental vouchers had been reserved.

As of September 30, 1991, approximately 30 percent of all Section 8 existing housing units were occupied by elderly or handicapped individuals, or by families in which at least one of the principal householders is elderly or handicapped.

Authorization is also provided for Shared Housing arrangements under Section 8 programs. One shared housing concept of particular interest to the elderly permits homeowners to rent space in their homes to nonrelated tenants who receive rental assistance. Such arrangements can facilitate companionship and security for the elderly as well as reducing housing costs.

Single Room Occupancy (SRO) housing is another option that some localities find especially beneficial for certain segments of the elderly population. SROs are eligible for assistance under both the rental certificate and the rental voucher programs.

III. COMMUNITY PLANNING AND DEVELOPMENT

A. COMMUNITY DEVELOPMENT BLOCK GRANT ENTITLEMENT PROGRAM

The Community Development Block Grant (CDBG) Entitlement program is HUD's major source of funds to large cities and urban counties for a wide range of community development activities. These activities help low- and moderate-income households, eliminate slums and blight, or meet other urgent community development needs. The CDBG program made approximately \$2.8 billion available to States and communities in 1990, the most recent year for which complete data is available. Approximately \$2 billion of this sum went to 741 metropolitan cities and 125 urban counties by entitlement, with individual amounts determined by formula.

Entitlement communities undertake a wide range of eligible activities in which elderly residents may benefit either directly or indirectly. The CDBG program is decentralized, and local communities are not required to report program beneficiaries by age. For this reason, it is difficult to determine the exact amount of CDBG funds that directly address the needs of the elderly. However, available data indicates that Entitlement communities budgeted \$15 million in Fiscal Year 1990 to assist senior citizen centers. Metropolitan cities planned to use \$8 million for this purpose, and urban counties, \$7 million.

Housing-related activities—primarily rehabilitation—constitute the primary use of Entitlement funding. These activities accounted for approximately \$949 million or 37 percent of all CDBG Entitlement expenditures in 1990. Housing rehabilitation activities include major renovations, minor home repairs, and weatherization services to owner and tenant occupied properties. Many local communities target some of these activities to benefit elderly homeowners and tenants.

Significant amounts of CDBG Entitlement spending for neighborhood improvements, public services, and other public works, directly or indirectly benefit the elderly. CDBG Entitlement grantees allocated about \$42 million for improvements to and operation of neighborhood facilities, \$12 million for the removal of architectural barriers, \$5.8 million for centers for the disabled, and \$242 million for other public facilities. Such activities provide significant benefits to the elderly.

B. CDBG STATE AND SMALL CITIES PROGRAM

The State Community Development Block Grant and HUD-Administered Small Cities programs are HUD's principal vehicles for assisting communities under 50,000 population that are not central cities. States and small cities use the CDBG funds to undertake a broad range of activities and structure their programs to give priority to eligible activities that they wish to emphasize.

As in the CDBG Entitlement program, States are not required to report to HUD the ages of individuals who benefit from their recipients' activities. Consequently, the level of benefits to the elderly cannot be estimated with certainty. The States and the Commonwealth of Puerto Rico allocated approximately \$845 million of State CDBG funds to local governments during Fiscal Year 1990. Approximately \$65 million or 33 percent of that portion of funds which were obligated supported housing-related activities such as the rehabilitation of private properties and weatheriza-

tion services. Some local governments target some of these activities to benefit elderly homeowners and tenants. Approximately \$92 million or 48 percent of State Small Cities CDBG obligated funds assisted public facilities and public services. Some local governments spend a portion of these funds for neighborhood facilities, senior citizen centers, centers for the disabled, and the removal of architectural barriers.

C. RENTAL REHABILITATION PROGRAM

The Rental Rehabilitation program was authorized by Section 17 of the Housing Act of 1937, as amended by the Housing and Urban Rural Recovery Act of 1983, and provided grants to States, cities with populations of 50,000 or more, urban counties, and approved consortia of units of general local government. In Fiscal Year 1991, Congress made \$70 million available for Rental Rehabilitation program grants. These grants finance the rehabilitation of privately owned rental housing and in order to help ensure that an adequate supply of standard housing is affordable to lower income tenants. In addition, rental assistance is provided to low-income families and displaced persons to help them afford the increased rent of rehabilitated units or to move to other housing.

Under the program 22,818 units were completed in Fiscal Year 1991. As of September 31, 1991 commitments had been issued for 45,693 projects containing 207,624 units, and all rehabilitation construction work had been completed in 45,693 projects containing 161,796 units. Elderly tenants account for approximately 16,000, or 11 percent of the occupied units in these buildings. The program was terminated at the end of FY 1991.

D. SECTION 312 REHABILITATION PROGRAM

Through the Section 312 Housing Rehabilitation Loan Program, HUD made loans for the rehabilitation of single-family and multifamily, residential, mixed use, and nonresidential properties.

In Fiscal Year 1991, 1,130 Section 312 loans totaling \$63.95 million were made in 146 communities. Of these, 1048 loans were used to rehabilitate single family (one-to-four-unit) properties and 82 loans were made for multifamily and commercial properties. Although comprehensive data on the ages of borrowers are not currently collected, available information suggests that over 20 percent of Section 312 single-family loan recipients were elderly. The program was terminated at the end of FY 1991.

E. HOME INVESTMENT PARTNERSHIP

A new program, created by the National Affordable Housing Act of 1990 provides assistance by formula to States and localities to rehabilitate, build, and provide other assistance for housing low- and moderate-income persons. Elderly who meet income requirements of the act may receive assistance under the program. For rental assistance, at least 90 percent of the funds must be used for families with incomes no higher than 60 percent of the area median and the rest for families with incomes no higher than 80 percent. The Congress appropriated \$1.5 billion for this program in FY 1992, the first year of its operations.

As a condition for receiving assistance under this program, a Comprehensive Housing Affordability Strategy (CHAS) must be prepared. Included in the CHAS narrative shall be a description of the characteristics, services and special housing needs of persons requiring special services, including the frail and elderly.

Under HOME a number of model programs are being developed to guide communities in developing local programs. Among them is a model program to provide home repair services for older homeowners and disabled homeowners. In addition, activities previously conducted under the Rental Rehabilitation and Section 312 programs are eligible activities under HOME.

F. EMERGENCY SHELTER GRANTS PROGRAM

The Emergency Shelter Grants Program provides funds to States, cities, urban counties 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.

In Fiscal Year 1991, Congress made \$73 million in Emergency Shelter program grants available to States, cities, urban counties and territories. HUD allocated approximately \$41 million to 318 Entitlement communities, with individual amounts

determined by formula. States distributed approximately \$32 million to cities and counties within their jurisdictions.

As in the CDBG Entitlement Program, States and communities are not required to report to HUD the ages of individuals who benefit from their recipients' activities. Consequently, the level of benefits to the elderly cannot be estimated with certainty. However, according to a HUD survey of shelter managers conducted in September 1988, it is estimated that approximately 2 percent of the homeless persons who are occupants of shelters on a typical night are 65 years of age or over.

G. SUPPORTIVE HOUSING DEMONSTRATION PROGRAM

The Supportive Housing Demonstration Program has two components, Transitional Housing and Permanent Housing for the Handicapped Homeless. The Transitional Housing Program is designed to provide short-term housing and support services that facilitate the transition of homeless persons to independent living. The program aids the acquisition, rehabilitation, or leasing of transitional housing facilities, the payment of operating costs, and supportive services. In Fiscal Year 1991, the Transitional Housing program awarded private nonprofit and governmental sponsors \$106.1 million to develop 109 projects.

The Permanent Housing for the Handicapped Homeless Program assists States in developing community-based, long-term housing and supportive services for handicapped persons who are homeless or at risk of becoming homeless. In Fiscal Year 1991 HUD awarded \$48.6 million to 80 projects that are developed in partnership with private nonprofit organizations.

H. SUPPLEMENTAL ASSISTANCE TO FACILITIES TO AID THE HOMELESS

The Supplemental Assistance to Facilities to Aid the Homeless (SAFAH) program helps communities provide a comprehensive service package that allows the homeless to become economically self-sufficient and return to the community. The program combines housing for the homeless with supportive services and places special emphasis on assisting homeless families with children and elderly persons. In Fiscal Year 1990, HUD awarded \$11 million to the States for supportive services, counseling, and other assistance to the homeless.

IV. OTHER ACTIVITIES

A. FAIR HOUSING AND EQUAL OPPORTUNITY

The Fair Housing Amendments Act which was effective March 12, 1989 provides for "housing for older persons" which is exempt from the requirement of nondiscrimination against families with children. Such housing is defined as (1) housing for the elderly provided under any State or Federal program designed and operated for this purpose, (2) housing intended and operated for occupancy by persons 62 or older, (3) housing intended and operated for occupancy by at least one person 55 or older per unit. "Over 55", housing must have significant facilities and services designated to meet the physical or social needs of older persons or show that provision of such facilities and services is impracticable and that such housing is necessary to provide important housing opportunities for older persons. Additionally, at least 80 percent of the units must be occupied by at least one person 55 years of age or older per unit and the publication of and adherence to policies and procedures by owners and managers must demonstrate their intent to provide housing for persons 55 years or older.

Of complaints filed with the Department from March 12, 1989 through September 30, 1991, familial status was alleged as a basis of discrimination in 5,950 complaints, which represents 26.1 percent of all complaints filed during that period. Many of these complaints were filed against housing providers who claimed the "housing for older persons" exemption. All complaints are investigated and resolved in accordance with the Act.

During 1991, HUD received four complaints alleging age discrimination in Federally assisted programs. Two of the four were forwarded to the Federal Mediation and Conciliation Service (FMCS) for mediation. The FMCS was unsuccessful in mediating the two complaints and the complaints were returned to HUD Regional Offices for investigation. The remaining two complaints are also being investigated by HUD Regional Offices.

B. AMERICAN HOUSING SURVEY

The 1989 National American Housing Survey, released December 1989, and subsequent biennial national surveys, contain special tabulations on the housing situations of elderly households in the United States. The tabulations are in the same format as those produced in previous years for Blacks and Hispanics, for households in the four census regions, and for central cities, suburbs, and nonmetropolitan areas. An elderly household is defined as one where the householder, who may live alone or be the head of a larger household, is aged 65 years or more. The tabulations include information on housing and neighborhood characteristics of the previous housing of recent movers, both owners and renters. Special information is provided on households in physically inadequate housing or with excessive cost burdens, and on households in poverty. Separate data are provided for elderly Black and Hispanic households.

ITEM 8. DEPARTMENT OF THE INTERIOR

JANUARY 8, 1992.

DEAR MR. CHAIRMAN: The Department of the Interior is pleased to provide you with the enclosed report in response to your letter of October 2, 1991, wherein you asked this Department to describe its activities on behalf of Older Americans.

The enclosed report includes information relating to the Departmental Office for Equal Opportunity, the Departmental Office of Personnel, the Office of Inspector General, the Geological Survey, the Office of Surface Mining Reclamation and Enforcement, the Bureau of Reclamation, the Bureau of Land Management, the Minerals Management Service, the U.S. Fish and Wildlife Service, and the Bureau of Mines. The National Park Service and the Bureau of Indian Affairs are in the process of compiling their respective reports, which will be forwarded to your office as soon as possible.

Interior is committed to ensuring that older Americans are beneficiaries of its programs and an effective and viable part of its work force. The enclosed report not only demonstrates, in part, the many outstanding accomplishments of Interior's bureaus and offices toward serving older Americans but it shows as well how older citizens and employees have been an invaluable resource throughout all aspects of Interior's operations.

Again, we thank you for allowing Interior the opportunity to make this report to your Special Committee on Aging.

Sincerely,

JOHN E. SCHROTE,
Assistant Secretary—Policy, Management and Budget.

Enclosure: a/s.

U.S. Department of the Interior—Activities on Behalf of Older Americans

As a result of America's aging and changing society, the Department of the Interior is faced with many new and exciting challenges toward enhancing its stewardship of America's public lands and natural, historical, and cultural resources. At Interior, these challenges have been examined closely and addressed through a recently developed Departmental Strategic Plan for Human Resources Management. The plan focuses upon Interior's commitment to service and the continuous improvement of its programs to attract the broadest base of Americans possible. To this effect, Interior has established many goals and initiatives in consideration of older Americans. Principles have been established for ensuring that employees and applicants are treated fairly in terms of employment regardless of their age.

By the year 2000, approximately 38 percent of Interior's current work force will be eligible to retire. In several key occupations the rate of retirement is projected to be much higher. The average Interior employee's age is 41.7 years compared with the average Federal employee age of 42 years. By the end of 1994, 50 percent of Interior's career Senior Executive Service members will be eligible to retire. By the year 2000, 60 percent of the work force in occupations such as personnel, budget, and contracting will be eligible to retire. Human resource management evaluations are currently underway to remedy the effect of losing these invaluable older workers. Other goals and accomplishments of Interior's various bureaus and offices are as follows:

DEPARTMENTAL OFFICE FOR EQUAL OPPORTUNITY

The Departmental Office for Equal Opportunity serves as the focal point for all civil rights and equal employment program functions in the Department of the Interior. In fiscal year 1991, OEO managed a departmentwide program for resolving equal employment complaints relative to Interior's employment practices. OEO provided leadership and direction for processing 340 complaints of alleged employment discrimination of which 15 percent alleged discrimination on the basis of age. For the benefit of Interior's work force, OEO established and proclaimed policies for efficiently managing complaints of alleged age discrimination. Training and education materials and programs were developed regarding age discrimination. Equal employment counselors were provided with training and technical assistance in counselling complainants with age discrimination grievances. And managers and supervisors were educated on their obligations to rid their work environments of age discrimination practices.

OEO collected and evaluated Interior workforce data based on age and other factors in an effort to identify barriers to equal employment opportunities. Briefings and reports were prepared for Departmental executives relative to the frequency, scope and type of age discrimination affecting the Department.

In terms of Interior's Federal financial assistance programs, OEO developed civil rights assurances covering age discrimination for Interior's recipients of Federal assistance. State and local recreation programs were evaluated to determine compliance with the Age Discrimination Act of 1975. OEO effected a total of 6,157 civil rights compliance reviews of Interior's federally assisted programs and activities to determine, among other concerns, whether they were free of age discrimination. State fish and wildlife licensing activities were evaluated for inappropriate age distinctions and other related barriers. OEO processed and resolved a total of eight civil rights complaints from the general public that alleged discrimination on the basis of age in programs and activities to which Interior provided Federal financial assistance. Moreover, continuous assistance was provided to bureaus and offices of the Department and State and local governments on the application of Interior's Federal assistance age discrimination policies. Additionally, the office processed hundreds of inquiries from Federal, State, and local government agencies, private organizations, and citizens regarding the Department's policies against age discrimination.

OFFICE OF THE SECRETARY—OFFICE OF PERSONNEL

The Departmental Office of Personnel reports that as of October 31, 1991, there were a total of 281 persons 70 years of age or older employed by the Department of the Interior. This figure represents a decrease of 55 employees or a 19 percent decline in comparison to FY 1991. Of the 281 employees, 22 were 80 years or older. Work schedules and occupations varied among the employees in the 80 years or older age group. A listing by occupation and work schedules of Interior employees 80 years and older, as of October 31, 1991, is being provided as a part of this report (See Attachment A). Also, a statistical profile of the total number of employees 70 years and older have been made a part of this report, (See Attachment B).

OFFICE OF INSPECTOR GENERAL

In Interior's Office of Inspector General (OIG), during FY 1991 there were 43 individuals promoted or hired as a result of job vacancy announcements, 10 persons were selected with ages ranging from 42 to 52 years of age. For FY 1991, 14 of the new hires or promotions were at the GS-12 to GM-15 pay grades. There were 2 GM-15 positions filled, both with persons over 40 years of age. Of the selections, only 7 persons were under 30 years of age and the balance of 6 persons ranged from 33 to 39 years of age. 52.22 percent of OIG employees are over 40 years of age; 57 percent of the employees in "Audits" are over 40; 41 percent of employees in "Administration" are over 40; and 37 percent of employees in "Investigations" are over 40. The maximum age for a new hire of a criminal investigator, which comprises the majority of the "Investigative staff" is 37 years. Employees over 40 contribute substantially to the success of the Office of Inspector General. Fifty-seven employees over 40 years of age were given OIG awards in FY 1991 ranging from \$500 to \$5,000, or quality step increases. This represents 58.1 percent of the total of 98 awards given during FY 1991 to all OIG employees. Three persons over 40 years of age were recognized by the Secretary of the Interior under the President's Thousand Points of Light Program for their work with the Boy Scouts of America, hearing impaired,

and church volunteerism. In addition, other OIG employees over 40 years of age have been recognized for similar types of volunteerism.

GEOLOGICAL SURVEY

The Geological Survey has a strong and ongoing commitment to utilize the knowledge and scientific expertise of its older employees.

1. *Employment Policy.* During the past year the Survey has continued to benefit from the wisdom and curative abilities of its older workers. The bureau continues to employ a large number of older employees and, as a result, obtains invaluable assistance for its programs from their many years of training and valuable on-the-job experience. In fact, out of a current workforce of about 10,970 employees, about 5,350 are older than 40 years of age.

Because of the very positive contributions of these employees, the Survey continues to maintain a strong and ongoing commitment to fully utilize the knowledge and scientific expertise of all its older employees.

2. *Older Worker Demographics.* The total increase in the percentage of older Americans as a specific segment within our society is an acknowledged fact of life in the 1990's. In 1965, the elderly made up 9.5 percent of the population, but by 1991 that figure has increased to 12.7 percent of the population. Particularly with respect to employment, America must deal with an increasingly older work force. The shrinking pool of young workers and the trends of early retirements and middle management layoffs are creating opportunities for employers to hire experienced older workers to fill a wide variety of needs. The decade of the 1990's will offer American employers a chance to prepare for the projected labor shortage in the next century by hiring older workers and allowing them to bring their leadership skills, talent, energy and commitment to the job. The increase in the number of older citizens in the United States of about 700,000 each year represents a serious challenge to our society to provide, among other things, good quality employment opportunities. Also, at the present time, it is estimated that nearly 40 percent of the geoscience population in the United States are age 50 or older. American Demographics Magazine recently indicated that 22 million Americans are 55 to 64 years old; 17 million are 65 to 74 years old; 10 million are 75 to 84 years, and 3 million 85 and older. In Virginia where the Geological Survey's headquarters is located it is estimated, by the Virginia Department of Budget and Planning, that the age 60 and older population will increase 91 percent between 1990 and the year 2000. Older workers are a valuable human resource on which many employers, including the Survey will have to rely more and more. Recent studies have indicated that employing older workers confirms several trends; older workers usually make excellent managers of people; older workers are generally loyal and committed to the job and have a low turnover rate; older employees are more likely to work hard, and older workers are less likely to have accidents on the job than younger, less experienced workers. Information such as this confirms the Survey's continuing commitment to employ older workers.

3. *Ongoing Program.* The Survey has at least one ongoing program which focuses directly upon aging employees—a continuing retirement planning program, operated by the Personnel Office, and geared to meeting the needs of all Survey employees. Retirement planning seminars are given on a regular cycle each year, in an effort to provide information for employees who are eligible for or contemplating retirement. The specific goal of these seminars is to provide all participants with sufficient knowledge of retirement issues so as to enable them to prepare adequately for retirement. The seminars usually include discussions of personal attitudes and adjustments required for successful retirement, financial planning, social security benefits, Federal civil service annuity benefits, and health maintenance. The seminars are well attended and are considered by participants to be very valuable.

4. *Retiree Contributions.* Another important bureau program emphasis for older workers involves retirees. A successful transition into retirement is a critical issue for the Survey, since a number of our retirees do come back as reemployed annuitants or as volunteers. Currently, the Survey has more than 150 reemployed annuitants who are 55 years or older still on the rolls. Their contributions in terms of research skills, creative abilities, and scientific knowledge are invaluable to the bureau's programs and projects. In the past, the Survey has not hesitated to utilize such individuals, because of the value of their contributions, and look forward to continuing this tradition in the future. Another one of the very distinctive strengths of the Survey is its relationship with tradition and the past. Over the past 100 years, the Survey has established a well-deserved reputation for excellence in earth science research. Its achievements are reflected by the large number of older men and women of science whose efforts have shaped and fostered its development.

Many of the most creative of these people have been Survey employees all of their careers. It is clearly recognized in the bureau that the professional experience which these people possess cannot be replaced. Most of them continue to be employed because they have no desire to stop the challenging work begun during their careers, and because the Survey has a need for and sincere interest in their knowledge of the organization and its mission. Their extensive expertise is a fund from which our younger employees can and do draw so that their own work can be enriched.

5. *Senior Employment Resources.* In an ongoing effort to expand recruitment of older Americans for employment consideration by the bureau, the Survey participates in the efforts of the Senior Employment Resources, a local northern Virginia nonprofit private placement agency, supported in part by Title III of the Older Americans Act funds, as well as other funding from Federal, State, and local governments. By providing job vacancy announcements to this organization the Survey is able to attract older candidates from their talent bank of individuals 55 years of age or older, who may be seeking full- or part-time employment with a Federal agency.

6. *Awards and Recognition.* Because the Survey has a limited number of specific programs directed exclusively toward older citizens or employees, the bureau constantly guides the positive impact of its older workers by consistently utilizing and recognizing their talents. Each year the Survey, in impressive ceremonies, provides appropriate public recognition honoring meritorious service and special achievements for its employees. Always included as a part of that public recognition is the presentation of many awards for length of service. Within the past year, the Survey was able to grant awards for 30 years of service to 135 older Survey employees; grant 23 awards to older employees for 40 years of service, and grant 2 awards to older employees for 50 years or more of service. Merit awards were also given to older employees, most of whom have attained the age of 55 or older, with one employee receiving the Geological Survey's Public Service Award, 10 employees receiving Superior Service Awards, 10 employees receiving the Meritorious Service Award, and 5 receiving the Distinguished Service Award. The Department of the interior's Stewardship for Science Award was also given to Dr. Isace Winograd, who has almost 36 years of service. The key to understanding the dedication of these talented people lies in an awareness that, in science, their work continues to be useful, productive, and unique. Still active, these employees continue to build upon their past achievements, while using their capabilities to continue to contribute to the future public welfare of our Nation through the Survey and its scientific programs.

7. *Retired Employee Organizations.* An important bureau policy, used by the Survey to foster and encourage the continued influence of older former employees, is demonstrated by the success of several retired employee organizations. Involving hundreds of different retirees and former employees, these groups forge an important link between current bureau programs and the former employees, themselves, and confirms that, among retired Survey employees, there is a strong and positive interest in the welfare of the bureau. Each of these groups provides opportunities during the year for social events such as picnics, discussion groups, and breakfast or luncheon meetings. Each retiree group produced its own newsletter and keeps membership rolls to encourage fellowship, social contact, and the sharing of news about Survey programs and projects; because they are independent and self-financed, each group operates at no cost to the public. Sponsored by retirees from each of the bureau's operating divisions, the activities initiated by these groups allow the retirees to maintain contacts with their former professional colleagues, and to support a variety of scientific activities. During the year, the Survey provides opportunities for retirees to meet with managers in the Survey's operating divisions, as well as with other bureau officials, to keep abreast of current division and bureau programs. The knowledge, skills, and abilities of our retirees are also fully utilized when they are encouraged to volunteer their time and talent to participate in ongoing programs and projects.

8. *Volunteer Programs.* In recent years, the Geological Survey has developed a large and very effective series of volunteer programs and projects in support of the research activities being carried out by the regular employees of the bureau. As part of that effort, retirees and other older persons are encouraged to volunteer their time and talents under one of these programs. Within the past year, more than 115 retirees have served as volunteers, with 20 of those individuals serving for tours and providing information about bureau programs to the public; one retiree met once a week at a local elementary school to teach sixth grade students in a project designed to give them actual experience in scientific research and analysis; one volunteer, a former business education teacher, assisted with clerical and administrative activities in support of our Volunteer for Science Program; many

senior citizens volunteered nationwide for the Water Resources Division to collect and analyze water quality data; both senior citizens and retirees, with backgrounds in mathematics and computer science, volunteered to teach software applications, enter data, and evaluate software and hardware upgrades within our Information Systems Division; many former employees and senior citizens served as mentors, coaches, and lecturers at a nearby elementary school in Reston, VA; a retired astrogeologist volunteered to lead a team of other volunteers to conduct monthly studies of asteroids at the Mt. Palomar Observatory, and many other older citizens and retirees have volunteered for charity walkathons and helped gather, sort, and distribute food, clothes, toys and books for needy families during the holidays.

9. *Summary.* Many of the Survey's operating programs demand a high level of scientific excellence, and there is a constant need for the appointment and retention of experienced and creative scientists and technical support personnel. The Survey has always practiced sound and effective personnel management policies, particularly with regard to the employment and most effective utilization of older workers. It has been, and will continue to be the expressed policy of the Survey to assure fair and equitable employment consideration for all applicants and employees, regardless of age. Because of its past successful experience with mature employees, the Survey will continue to make extensive use of the knowledge, abilities, and skills of its older workers.

OFFICE OF SURFACE MINING RECLAMATION AND ENFORCEMENT

The Office of Surface Mining Reclamation and Enforcement (OSM) has a total of 1,058 employees of which 686 or 64 percent are 40 years of age or older. OSM also has one employee who is over age 70. The Equal Employment policy statement that was previously issued to all OSM employees, which addressed nondiscrimination of older employees, is still in effect. Also, in an effort to increase awareness of the growing population of aging in the workplace and society as a whole, the Equal Employment (EO) and Personnel Offices have sponsored several activities. The EO Office has provided employees with appropriate training with discussions of age discrimination and the Office of Personnel's Employee Assistance Program provided OSM employees with a 2-hour seminar entitled, "Caring for Elders—Locally and Long Distance." The latter seminar provided employees of aging parents with much needed information on strategies for coping with the aged. In order to continue increasing awareness and educating OSM employees on issues of aging, the EO Office will provide pamphlets and videotapes.

BUREAU OF RECLAMATION

The Bureau of Reclamation conducts many activities that affect and benefit aged individuals throughout the year. Our Personnel Offices maintain contact and provide services to many retirees who need advice or have questions concerning their retirement and health benefits. In addition, retirees and their spouses attend annual health insurance fairs where insurance representatives are available to discuss the provisions or changes to their respective medical plans. Several of our regional offices mail out a monthly newsletter to all retirees. The newsletters contain information on Reclamation, current employees, and this practice is highly regarded by retirees as a way to keep in touch.

Employment Opportunities. Reemployed annuitants are hired to perform special projects or provide assistance in specialized technical areas of work. Annuitants are able to offer invaluable experience and expertise to these assignments. Reclamation continues to stress employment of older Americans in occupations where their years of experience and expertise in specialized work areas are invaluable to the mission of Reclamation, such as Civil, Electrical, and Mechanical Engineers, Construction Inspectors, and Hydroelectric Mechanics. Regional Offices have opened many of their vacancy announcements for job sharing and part time applications in order to offer senior individuals an opportunity to work on a part-time basis. At Reclamation's Great Plains Region, project offices are pursuing recruitment of retired senior citizens interested in summer employment to conduct dam and power plant tours in resort areas, due to availability of candidates in these localities. Mainly, recruitment is conducted using local job services.

Handicapped Access. The Great Plains Region is in the process of conducting a handicap accessibility study throughout the dams, powerplants, and recreational areas and continues to work on activities which will afford greater accessibility to facilities by the disabled, many of whom are older citizens.

Recreation. At the Bureau of Reclamation's Yuma Projects Office, Yuma, AZ, there are frequent special tours conducted of the Yuma Desalting Plants for "winter visitors" who are mostly retiree/tourists.

In the Great Plains Region, Billings, MT efforts continue with regard to enhance recreational opportunities at many reservoirs and recreational areas which have traditionally attracted many senior citizens and retired individuals.

Volunteers. Senior volunteers are utilized in Reclamation's work force in many program areas including clerical, secretarial, engineering, natural resources, computers, administrative, data entry, and special projects like handicap accessibility studies.

Seminars. Pre-retirement briefings and seminars are held for all interested employees who are within five years of retirement eligibility. In the Pacific Northwest Region, all Equal Employment Opportunity and Personnel Office staff attended age discrimination training titled: "Age Discrimination: No Gray Areas." The purpose of the training was to sensitize employees with personnel and equal employment opportunity responsibilities to those issues which are of concern to the aging work force as anticipated by the Bureau of Reclamation and as reported in *Work Force 2000* and other studies.

Awards/Recognition. The Great Plains Region granted two Superior Service Awards to senior employees and a Department Unit Award for Excellence of Service which included some senior employees, during the fiscal year. Several performance awards were presented to senior employees also.

BUREAU OF LAND MANAGEMENT

The Bureau of Land Management (BLM) is committed to administering a natural resource program for all individuals that is free from discrimination based on age, sex, national origin, race, color, religion or handicap and to promoting equal opportunity through our policies and practices affecting employees, applicants, and users of the public lands.

Of the 11,756 employees in the BLM work force as of September 30, 1991, 6,018 are over 40 years of age (51 percent), and 63 are over 65 years of age. In addition, approximately 14,000 volunteers contribute their skills and services to the BLM in support of continuing and special functions, including 980 who are over 65 years of age (7 percent). During 1991, several of the senior volunteers received the BLM's Exemplary Volunteers for Public Lands Award for their outstanding service as volunteers.

The BLM carefully monitors operating conditions to ensure employees and members of the public have access to BLM employment installations, facilities, and programs, without illegal discrimination or restricted access based upon age.

MINERALS MANAGEMENT SERVICE

The Minerals Management Service (MMS) continues to work to support programs for older Americans. MMS's work force statistics are as follows:

The MMS work force, age 40 and over, continued to increase during the past year from 50 percent in 1990 to 65 percent in 1991 (1,320 of 2,044). Of the total, 117 employees are over age 60, an increase of 5 from 1989 with 22 workers over age 65 and 8 over age 70.

Older employees are well represented in a variety of occupations within MMS including accountants, auditors, computer specialists, engineers, and physical scientists.

The needs of older workers are addressed through MMS's employee development program. Retirement planning workshops are regularly attended by eligible MMS employees. For example, in 1991, 152 employees (7 percent of the total work force) attended the retirement planning workshops. Of this number, 28 persons actually retired. In addition, MMS managers and supervisors continue to receive equal employment opportunity training which includes age discrimination and how to avoid it. The result of such training is reflected in the number of discrimination complaints filed on the basis of age with the MMS during the year. In 1990, a total of 18 complaints were filed by older employees as compared to 9 complaints filed in 1991.

The MMS has implemented and continues to implement effective personnel management policies to reinsure that equal opportunity is provided to all employees and applicants, including the aged.

The MMS continues to perform its mission-related functions with diligence and with appreciation of the importance of our actions. A major mission responsibility affecting large numbers of citizens is the approval of 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 these financial responsibilities.

The MMS offshore mission has the ultimate objective of increasing domestic mineral (oil and gas) production through offshore resources, thereby decreasing our dependence on foreign imports. Such activities have a significant effect on the economic well-being of all Americans, especially older Americans.

In summary, the MMS has a strong commitment to all of its employees, including older workers. Older workers are a source of valuable knowledge and experience and a significant factor in the success of the MMS mission.

U.S. FISH AND WILDLIFE SERVICE

The Fish and Wildlife Service (Service) recognizes its responsibility for providing opportunities to all citizens throughout its system and strives to ensure that senior citizens are utilized and supported through special programs, volunteerism, employment opportunities and modification of facilities to improve accessibility. The Service employs a total of 8,909 persons. Of that number, 4,601 employees are 40 years of age and older. This represents 51 percent of the total work force. Of the 4,601 employees, 250 are 60 years and older and work various schedules in a wide variety of occupations with the majority employed in the biological sciences positions. The following occupational categories are reflective of that group: 2,013 professional; 799 administrative; 589 technical; 541 clerical; 641 wage and Job Corps; and 9 other. Being aware of the demographic changes taking place in the work force, the over 40 years of age population in the Service is growing rapidly. To meet present and future demands for skills the Service must creatively use resources of the older population. The Service is the world's leading wildlife resource agency. To sustain this leadership position, the Service has increased its training programs to meet the challenges of this decade and into the new century. The Service is committed to serving the needs of older employees by providing accessibility to employment opportunities, training and other services to those who wish to remain active.

The Service provides equal opportunities to all applicants and employees regardless of age. Managers and supervisors are encouraged to ensure fairness in the treatment of all employees and to recognize the contributions of employees who have served the Service for many years. During the past year, 62 Service awards were presented to employees with 30 or more years of service.

The Office for Human Resources provides training and technical assistance to Service managers, supervisors and equal employment opportunity counselors on the regulations and guidelines governing age discrimination law. This training enhances their skills by enabling them to informally resolve complaints and sensitizing them to the rights of employees who are 40 and older. During fiscal year 1991, a total of three complaints were filed on the basis of age, in comparison to five received in fiscal year 1990.

Numerous opportunities exist with the Service for retirees and older persons to serve as volunteers in a broad spectrum of professional, technical, administrative, and clerical professions. Many volunteers have contributed as many as 20 years of service and donated over 2,800 hours toward improving public use facilities at fish hatcheries and wildlife refuges. As a scientific agency, the Service continues to rely on the expertise of senior individuals for highly specialized technical and extensive experience in research, analysis, development, and assessment activities. Highlighted areas of volunteerism include: retired biologists, zoologists, and teachers who have developed and presented environmental educational programs targeted for a vast majority of public schools and boy/girl scouts organizations nationwide. Others have conducted census studies, surveys, and assisted in the control of the predator-prey relationship. In addition, they staffed visitor centers; performed maintenance work, and provided office assistance.

Ongoing is the successful Take Pride in America Program. Each year, many senior citizens are honored as winners of the Take Pride in America Awards. For example, in the area of partnership, over 250 volunteers (mainly senior citizens) worked together collectively with the Arkansas National Wildlife Refuge; Texas Waterways Operators Association; and Conoco Incorporated, for the protection of whooping cranes.

The Golden Age and Golden Access Passport Programs provide free lifetime entrance permit or lower entrance fees to recreational areas and federally operated facilities for people over the age of 62 and persons with disabilities. In 1990, 405,963

passports were issued by all Federal recreational agencies. Of that number, the Service issued 29,895.

The Service receive a significant portion of written and telephonic inquiries from retired individuals who are interested in natural resource oriented issues, especially concerning endangered species and non-game birds and animals. The Service's publication unit makes available educational materials, provides practical method and techniques to enhance fish and wildlife habitats to the public.

Efforts have increased in making programs, activities and facilities more accessible to persons with disabilities and to meet the needs of older employees and citizens. For example, a major construction project was completed at Leavenworth National Fish Hatchery by Service personnel, private industry, and Trout Unlimited (approximately 1,500 volunteer hours). In addition, one volunteer, Mr. Irv Garvey, received the Silver Eagle Award for his long-term contributions spent in spawning and processing thousands of returning salmon and steelhead through the traveling screen modification project at this facility.

BUREAU OF MINES

As a scientific organization, the Bureau of Mines values the technical expertise that is representative of a person who has long and extensive experience in research, analysis, development, and assessment activities. The expertise of senior individuals for the bureau's highly specialized technical and scientific positions is reflected by the following:

1. The Bureau currently employs 192 employees age 60 and over. This equates to 7.8 percent of the Bureau's work force.
2. Fifty-three percent of bureau employees age 60 and over are in professional positions.
3. Four percent of Bureau employees age 60 and over are minorities.
4. Eight employees were hired age 60 and over during this reporting period.

Forty-five Bureau employees age 60 and over retired during this reporting period. The servicing personnel offices provided individual retirement counseling and issued periodic information and reminder notices regarding pre-retirement seminars to bureau employees who where either undecided about retirement or would be eligible for retirement within a specific number of years. The Bureau of Mines will continue to utilize hiring authorities to employ reemployed annuitants, members of the Secretary's Advisory Committee, and college/university faculty. During 1991, the bureau awarded 75 awards to employees age 60 and over of which two employees received Superior Service Awards, and six senior employees received Meritorious Awards. A review of internal and external employment policies shows that the Bureau of Mines has and continues to support the interests and needs of the aging through its diversified programs and service.

BUREAU OF INDIAN AFFAIRS

In 1991, the Bureau of Indian Affairs (BIA) provided and financed a monthly average of 1,150 adults with custodial and protective care services. These services were provided in the homes, in group homes or nursing care facilities for elderly persons who had no other resources. Many other adults received protective and counseling services only, but without custodial care payments. BIA also participated in several joint meetings with other Federal agencies to coordinate plans and services for the elderly.

In 1992, the BIA, through interagency meetings, will focus on identifying barriers encountered by older Indians. Meetings and planning will be increased with the Social Security Administration, the Administration on Aging, the Indian Health Service, and in some instances with State agencies. A task force with membership from key agencies was initiated by the Indian Health Service in 1991. The BIA intends to participate fully with task force in FY 1992.

NATIONAL PARK SERVICE

The National Park Service (NPS), over the past few years, has made significant efforts to insure that the full range of the visiting public, including senior citizens, can get into our parks and once there, can participate in and receive the benefits of the programs and services provided.

One step taken by the NPS to improve accessibility was to create a special unit in its Washington Office to monitor and coordinate the entire systemwide effort. It was determined by NPS management that the issue should be approached in a comprehensive, organized way rather than on a project-by-project basis. Accordingly, in

1979, the Special Programs and Populations Branch was established and staffed with individuals who have experience in recreation and park programming with special populations. The primary goal of the Branch is to develop and coordinate a systemwide, comprehensive approach to achieve the highest level of accessibility that is feasible while at the same time, assuring consistency with other legal mandates of preservation and protection of NPS managed resources. Since its creation, the Branch has been working with resource persons in each of the regional offices and other NPS units to assess the current level of accessibility of our various parks, identify the barriers to accessibility, develop policies and guidelines regarding appropriate methods and techniques for improving access, and providing technical assistance and in-service training on cost effective approaches and program implementation. Through these coordinated efforts, NPS has been recognized as a leader in opening opportunities for persons with disabilities and senior citizens as well.

At the present time, continued efforts are being made to increase the number of older citizens in the Service's Volunteer-in-the-Parks (VIP) Program. In this regard, NPS is currently working with the American Association of Retired Persons (AARP). Since 1983, the number of participants in this program has increased from 4 percent to 14 percent.

Another major effort of NPS, as it relates to senior citizens is providing Golden Age Passports. The passport is a free, lifetime entrance permit to those recreation areas administered by the Federal Government that charge entrance fees. Passports are issued to citizens or permanent residents of the United States who are 62 years of age or older. The passport holder also gets a 50 percent discount on Federal use fees charged for facilities and services such as camping, boat launching, and parking. Since 1975, when this program was changed from a 1 year permit to a lifetime permit, NPS has issued approximately 3 million passports. In 1985, over 300,000 passports were issued by all Federal recreation agencies. In 1986, 205,013 passports were issued; in 1987, 269,064; and in 1988, 434,285 passports were issued. Data for 1989, shows a slight decrease to 369,056 in the number of Golden Age Passports issued by NPS. Data for 1989 shows that all Federal recreation agencies issued 491,965 passports. In 1990, statistics show a continued decrease to 386,690 passports issued by all Federal agencies. Statistical data for 1991 will not be available until early 1992.

The National Park Service is increasingly becoming more accessible for all citizens including the elderly and other special populations. This is due to NPS's continuing efforts to remove barriers that inhibit special populations from experiencing and enjoying the national parks. Many senior citizens, who are experiencing the loss of hearing, problems with visual acuity, and mobility impairments, benefits from these programs, and facility modification. Large type materials, captioned audiovisual programs, audio messages for the blind, and adaptations for wheelchair users are all modifications from which senior citizens can benefit. In 1986, NPS published the report of the 1982-83 Nationwide Recreation Survey (NRS). This report included a chapter on "Aging and Outdoor Recreation" which was based on a series of questions sponsored by the Administration on Aging and asked of respondents of 60 and over. A major user of the NRS data in 1986 was the President's Commission on Americans Outdoors. The commission report, published in July 1987, emphasized the implication of an aging United States population and a greater diversity of interest and ability among older Americans for the future of the parks and other recreation resources.

The NPS continues to provide financial assistance to State and local governments for recreation and acquisition and development under and the Land and Water Conservation Fund (LWCF) Program. Under this and other financial assistance programs, NPS encourages and monitors grant recipients to ensure that adequate provisions are in place to ensure access to assisted recreation facilities and services for elderly citizens, in accordance with the Age Discrimination Act 1975 and section 504 of the Rehabilitation Act of 1973, as amended.

The NPS provides financial and technical assistance to States for Statewide Comprehensive Outdoor Recreation Plans under the LWCF. One of the major objectives of such planning is to identify and address the recreation needs of special populations, including the elderly and people with disabilities. Statewide Comprehensive Outdoor Recreation Plans are critical in that they are the major policy document for implementation of outdoor recreation at the State level. In addition, a number of urban communities also continue with special planning and recreation programming efforts for senior citizens initiated in earlier years with grants from the Urban Park and Recreation Recovery Program.

The NPS continues to monitor and identify the number of employees who are 60 and over. In 1988, the survey indicated a decrease in the number of employees in

this age group. However, in 1989 and in 1990, the survey indicated that employees 60 and older are at all levels. These results showed a slight increase in the total number employed. In 1991, 1,478 employees were age 60 and over. These 1,478 employees were equally divided between permanent and temporary employment. About 5 percent of the permanent workforce is age 60 and over. Although the overall total is a 6 percent decrease from the proceeding year (1,566), a trend is not readily apparent. (In 1988, the number of employees in this age group decreased; 1989 and 1990 data indicated that employees 60 and over were at all GS levels, as increase in the total number employed.) The NPS will continue to monitor this situation and will continue efforts to improve services to this age group.

OCCUPATIONS AND WORK SCHEDULES OF DEPARTMENT OF THE INTERIOR'S EMPLOYEES
80 YEARS AND OLDER AS OF OCTOBER 31, 1991

- Bureau of Land Management: Intermittent Engineering Equipment Operator—Age—80
- Bureau of Indian Affairs: Full-time Boiler Plant Operators—Age—81
- U.S. Geological Survey:
 - Full-time Geologist—Age—80
 - Intermittent Hydrologist—Age—80
 - Intermittent Research Geologist—Age—80
 - Intermittent Professional Services Specialist—Age—80
 - Intermittent Geologist—Age—84
 - Intermittent Geologist—Age—82
 - Intermittent Geologist—Age—90
- Bureau of Mines:
 - Full-time Physical Scientist—Age—82
 - Intermittent Physical Scientist—Age—81
- National Park Service:
 - Part-time Small Craft Operator—Age—80
 - Full-time Laborer—Age—80
 - Full-time Park Ranger—Age—80
 - Full-time Laborer—Age—82
 - Full-time Park Ranger—Age—82
 - Intermittent Park Ranger—Age—82
 - Part-time Landscape Architect—Age—84
- Fish and Wildlife Service:
 - Full-time Carpenter—Age—80
 - Part-time Range Aid—Age—81
 - Part-time Laborer—Age—82
- Minerals Management Service:
 - Full-time Fiscal Data Analyst—Age—80

1991 REPORT TO THE SENATE COMMITTEE ON AGING

U.S. Department of the Interior 70 Years and Older

Age:	<i>Total No. of employees</i>
70	65
71	64
72	37
73	33
74	18
75	10
76	7
77	13
78	5
79	7
80	9
81	3
82	6
83	0
84	3
85	0
86	0
87	0
88	0
89	0

90	1
Total	281
As of October 31, 1991	

ITEM 9. DEPARTMENT OF JUSTICE

WASHINGTON, DC, *November 12, 1991.*

DEAR MR. CHAIRMAN: I am pleased to transmit to you and the Members of the Special Committee on Aging the submission of the Department of Justice for Volume II of *Developments in Aging*.

Within the Department, the Office of Justice Programs (OJP) is responsible for a number of initiatives relating to older Americans. For example, OJP collects information about the numbers and characteristics of crimes committed against elderly citizens and sponsors programs to improve the treatment of elderly and other victims of crime and help protect senior citizens and their neighborhoods from crime and violence through crime and drug abuse prevention and control programs. In addition, the Office of Justice Programs provides grant funds to the states that may be used to support State and local criminal justice programs that serve older Americans.

Through initiatives such as these, the Department of Justice is working to ensure the safety and well-being of our Nation's senior citizens. I appreciate having the opportunity to report to the Committee regarding these initiatives on behalf of older Americans. Please do not hesitate to contact me if I may be of further assistance.

Sincerely,

W. LEE RAWLS,
Assistant Attorney General.

Enclosure.

U.S. DEPARTMENT OF JUSTICE—OFFICE OF JUSTICE PROGRAMS

The U.S. Department of Justice's Office of Justice Programs (OJP) sponsors a number of initiatives that affect older Americans. The Office of Justice Programs was created in 1984 to provide the Federal leadership and coordination necessary to make the Nation's criminal justice system more efficient and effective. OJP works to form partnerships among Federal, State, and local government officials to improve the administration of justice in America, identify emerging criminal justice issues, develop and test promising approaches to address these issues, evaluate program results, and disseminate these findings and other information to the Nation.

OJP's Bureau of Justice Assistance (BJA) administers the Edward Byrne Memorial State and Local Law Enforcement Assistance Program authorized by the Anti-Drug Abuse Act of 1988. This program provides financial and technical assistance to States and units of local government to control crime and drug abuse and to improve the criminal justice system at the State and local levels. States may use these Federal funds to support a variety of criminal justice programs that affect elderly citizens, including projects to protect senior citizens from physical and mental abuse, prevent consumer fraud directed at them, promote community awareness and crime prevention among the elderly, and provide assistance for elderly victims of crime.

In addition, BJA's national discretionary grant program tests new techniques and provides training and technical assistance in program implementation. One major initiative is the National Citizens' Crime Prevention Campaign, which provides crime prevention and personal safety information to elderly citizens throughout the Nation. The Campaign features "McGruff, the Crime Dog," who asks Americans to help "Take A Bite Out of Crime" by taking simple precautions, by reporting suspicious activity to the police, and by working with their neighbors, community leaders, law enforcement officials, and others to keep their communities safe from crime and drugs.

The Campaign is administered through a partnership among OJP/BJA, the National Crime Prevention Council, the Crime Prevention Coalition, and the Advertising Council, Inc. Information packets developed by the Campaign and distributed across the country include special crime prevention tips for senior citizens and focus on the special needs, concerns, and vulnerabilities of elderly citizens with regard to crime and victimization. The Campaign also works to enlist senior citizens in the fight against crime and drugs, recognizing them as a valuable resource for community crime prevention programs. Its informational materials and public service ad-

vertising encourage older Americans to participate in crime prevention activities in their communities.

Under its BJA grant, the National Crime Prevention Council has developed a special *Topics in Crime Prevention* entitled "Working With Older Americans," which focuses exclusively on working with older Americans in crime prevention efforts. This publication highlights self-protection methods for seniors, helps raise awareness of society's attitudes towards its elders and their concerns, provides practical guidelines for working with the growing population of senior citizens, and addresses the complex issue of elder abuse. The report is distributed through the 138 member organizations of the Crime Prevention Coalition and through crime prevention practitioners throughout the country.

OJP's Bureau of Justice Statistics (BJS) collects, analyzes, publishes, and disseminates statistical information on crime, criminal offenders, victims of crime, and the operations of criminal justice systems at all levels of government. Each year, BJS publishes *Criminal Victimization in the United States*, an analysis of data collected through its National Crime Survey. Data concerning crime victims age 65 and older are presented by race, gender, percentage of crimes committed by strangers against the elderly, perceived age of offenders victimizing the elderly, use of self-protective measures by those 65 and older, extent of injury, medical and hospitalization involving the elderly, and the extent to which the elderly report their victimization to police. In addition, BJS issued a Special Report on *Elderly Victims* in 1987. These studies have shown that while elderly citizens express a greater fear of crime than persons in other age groups, older Americans are actually less likely to be victims of crime.

OJP's National Institute of Justice (NIJ) sponsors research and other programs to control crime and drug use and to improve the effectiveness of the criminal justice system. During 1991, NIJ entered into a working relationship with the National Sheriffs' Association, the International Association of Chiefs of Police, and the American Association of Retired Persons. These organizations are cosponsors of the Triad Program, a nationwide effort designed to assist local teams of law enforcement personnel, elderly volunteers, and victim service providers in coordinating efforts to prevent crimes against the elderly and to provide assistance to elderly victims. NIJ will fund the development of a Training and Implementation Manual, a Sourcebook of Crime Prevention and Victim Assistance Resources for use by the elderly, and the script for a video to encourage implementation of Triad Programs throughout the country.

OJP's Office for Victims of Crime (OVC) serves as the Federal focal point for addressing the needs and improving the treatment of crime victims. This includes administering the two programs—victim compensation and assistance—mandated by the Victims of Crime Act (VOCA) of 1984, as amended, monitoring compliance with the provisions regarding assistance for Federal crime victims as provided for under the Victim and Witness Protection Act of 1982, and implementing the recommendations of the President's Task Force on Victims of Crime, the Attorney General's Task Force on Family Violence, and the President's Child Safety Partnership.

A 1988 amendment to VOCA requires States to set aside 10 percent of the funds awarded by OVC for victim assistance programs for previously underserved victims of violent crime. A number of States identified elder abuse victims as a previously underserved group for which they provided additional programs and services. Other States and territories award subgrants from VOCA victim assistance funds to local victim services agencies that aid elderly victims of abuse and crime.

Under the VOCA victim compensation grant program, elderly victims and survivors of elderly victims of violent crime are eligible to receive reimbursement for expenses related to their victimization. These include medical expenses, including mental health counseling and care, funeral expenses, lost wages, and other costs associated with the crime.

In addition, during 1991, OVC awarded a grant to the Victim Services Agency in New York City to provide training for victim service providers in identifying, assessing, and treating elderly victims of physical, emotional, and financial abuse by adult children or other family members. The overall goals of the training effort are to sensitize service providers to the problems experienced by elderly victims of abuse and to increase the capabilities of service providers. The project also will produce an *Elder Abuse Resource Directory*, which will list elder abuse service providers in New York City and throughout the United States.

OVC also is developing a program that will design a curriculum to train law enforcement agencies in responding to cases of elder abuse. This program will be funded in late 1991.

Copies of research and statistical reports and other information published by the Office of Justice Programs is available by calling the National Criminal Justice Reference Service toll-free on 1-800-851-3420. From metropolitan Washington, D.C., and Maryland, call 301-251-5500.

Additional information about the Office of Justice Programs is available from the: Office of Congressional and Public Affairs, Office of Justice Programs, 633 Indiana Avenue, N.W., Washington, D.C. 20531, Telephone: 202-307-0781.

ITEM 10. DEPARTMENT OF LABOR

JANUARY 13, 1992.

DEAR CHAIRMAN PRYOR: Enclosed is a summary of the programs and activities of the Department of Labor for fiscal year 1991 related to aging.

Described in the report are programs administered by the Employment and Training Administration, the Pension and Welfare Benefits Administration, and the Bureau of Labor Statistics.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

LYNN MARTIN.

Enclosure.

U.S. DEPARTMENT OF LABOR, FISCAL YEAR 1991, REPORT ON PROGRAMS AND ACTIVITIES RELATED TO AGING

EMPLOYMENT AND TRAINING ADMINISTRATION

INTRODUCTION

The Department of Labor's (DOL's) Employment and Training Administration (ETA) provided a variety of training, employment, and related services for the Nation's older individuals during program year 1991 (July 1, 1990-June 30, 1991) through the following programs and activities: the Senior Community Service Employment Program (SCSEP); programs authorized under the Job Training Partnership Act (JTPA); and the Federal-State Employment Service system.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

The Senior Community Service Employment Program authorized by Title V of the Older Americans Act, employs low-income persons age 55 or older in a wide variety of part-time community service activities such as health care, nutrition, home repair and weatherization programs, and in beautification, child care, conservation, and restoration efforts. Program participants work an average of 20 hours per week in schools, hospitals, parks, community centers, and in other government and private, nonprofit facilities. Participants also receive personal and job-related counseling, annual physical examinations, job training, and in many cases referral to regular jobs in the competitive labor market.

More than 80 percent of the participants are age 60 or older, and over half are age 65 or older. Seventy-one percent are female, about half have not completed high school, and all enrollees have a low income.

Table 1 below shows SCSEP funding, enrollment, and participant characteristics for the program year July 1, 1990, to June 30, 1991.

Table 1.—Senior Community Service Employment Program (SCSEP): Funding, enrollment, and participant characteristics—Program Year July 1, 1990, to June 30, 1991

Funding.....	\$367,013,000
Enrollment:	
Authorized positions established.....	\$64,930
Unsubsidized placements.....	\$14,051
Characteristics: ¹	
Sex:	
Male	29
Female.....	71
Educational status:	
8th grade and less	25
9th grade through 11th grade.....	21
High School graduate or equivalent.....	35
1-3 years of college	13
4 years of college or more.....	5

Veterans.....	13
Ethnic Groups:	
White	62
Black	24
Hispanic	9
American Indian/Alaskan Native	2
Asian/Pacific Island.....	3
Economically disadvantaged	100
Poverty level or less	80
Age groups:	
55 to 59	17
60 to 64	25
65 to 69	26
70 to 74	18
75 and over	13

¹ In percent.

Source: U.S. Department of Labor, Employment and Training Administration (Preliminary Data).

JOB TRAINING PARTNERSHIP ACT (JTPA) PROGRAMS

The Job Training Partnership Act (JTPA) provides job training and related assistance to economically disadvantaged individuals, dislocated workers, and others who face significant employment barriers. The ultimate goal of JTPA is to move program participants into permanent, self-sustaining employment. Under JTPA, Governors have approval authority over locally developed plans and are responsible for monitoring local program compliance with the Act. JTPA functions through a public/private partnership which plans and designs training programs and delivers training and other services. Private industry councils, in partnership with local governments in each service delivery area, are responsible for providing guidance for and oversight of job training activities in the area.

JTPA places emphasis on increasing the post-program employment and earnings of economically disadvantaged and displaced workers. Seventy percent of the funds available to service delivery areas are required to be spent on training. Not more than 15 percent may be spent for the costs of administration, and not more than 30 percent may be spent for the combined costs of administration and supportive services.

Basic JTPA Grants

Title II-A of JTPA authorizes a wide range of training activities to prepare economically disadvantaged youth and adults for employment. Training services available to eligible older workers through the basic Title II-A grant program include on-the-job training, institutional and classroom training, remedial education and basic skills training, and job search assistance and counseling. Table 2 shows the number of persons 55 years of age and over who terminated from the Title II-A program during the period July 1, 1990, through June 30, 1991. (The data do not include the 3 percent set-aside for older individuals, which is discussed separately.)

TABLE 2—JTPA ENROLLMENT JULY 1, 1990—JUNE 30, 1991

(Title II-A grants)

Item	Number served	Percent
Total Terminees.....	528,087	100.0
55 years and over	6,923	1.3

Source: U.S. Department of Labor, Employment and Training Administration (September 1991 Preliminary Data)

Section 124 Set-Aside

Section 124 of JTPA calls for 3 percent of the Title II-A allotment of each State to be made available for the training and placement of older individuals in employment opportunities with private business concerns. Only economically disadvantaged individuals who are 55 years of age or older are eligible for services funded from this set-aside.

JTPA offers wide discretion to the Governors in using the set-aside. Two major patterns have evolved. One is its use for organizationally distinct older worker projects in a manner similar to the categorical separation of SCSEP programs from the rest of the JTPA system. The other is the use of the set-aside as a resource for Title II-A programs to ensure a minimum portion of older workers among Title II-A participants, without the creation of separate programs for older workers. In some States, all or part of the set-aside is formula-funded to service delivery areas. In other States, it is used for administration at the State level, for model programs, or for both purposes. For program year 1991 (July 1, 1990, through June 30, 1991), preliminary data indicate that the 3 percent set-aside program for economically disadvantaged individuals 55 years of age and over enrolled almost 31,000 participants.

Programs for Dislocated Workers

Title III of JTPA authorizes a State and locally administered dislocated worker program which provides training and related employment assistance to workers who have been, or have received notice that they are about to be, laid off due to a permanent closing of a plant or facility; laid-off workers who are unlikely to be able to return to their previous industry or occupation; and the long-term unemployed with little prospect for local employment or reemployment. Those older workers eligible for the program may receive such services as job search assistance, retraining, pre-layoff assistance and relocation assistance. During the period July 1, 1990, through June 30, 1991, approximately 13,000 individuals 55 years of age and over went through the program (7.8 percent of the program terminations).

THE FEDERAL-STATE EMPLOYMENT SERVICE SYSTEM

The State-operated public employment service offices offer employment assistance to all jobseekers, including middle-aged and older persons. A full range of basic labor exchange services are provided, including counseling, testing, job development, job search assistance, and job placement. In addition, labor market information and referral to relevant training and employment programs are also available.

In response to the paperwork reduction initiatives, Federal reporting requirements for the State Employment Service (ES) agencies no longer include data on the characteristics of applicants. Therefore, information is not available at the national level on the number of middle-aged and older persons served by the ES. Individual ES offices may, however, have such data.

PENSION AND WELFARE BENEFITS ADMINISTRATION

INTRODUCTION

The Pension and Welfare Benefits Administration (PWBA) is responsible for enforcing the Employee Retirement Income Security Act (ERISA). PWBA's primary responsibilities are for the reporting, disclosure, and fiduciary provisions of the law.

Employee benefit plans maintained by employers and/or unions generally must meet certain standards, set forth in ERISA, designed to ensure that employees actually receive promised benefits. Employee benefit plans exempt from ERISA include church and government plans.

The requirements of ERISA differ depending on whether the benefit plan is a pension plan or a welfare plan. Pension plans provide retirement benefits, and welfare plans provide a variety of benefits, including others such as employment based health insurance, disability, and death benefits. Both types of plans must comply with provisions governing reporting and disclosure to the Government and to participants (Title I, Part 1) and fiduciary responsibility (Title I, Part 4). Pension plans must comply with additional ERISA standards (contained in both Title I, Parts 2 and 3, and Title II) which govern membership in a plan (participation), nonforfeatability of a participant's right to a benefit (vesting), and financing of benefits offered under the plan (funding). Welfare plans providing medical care must comply with ERISA continuation coverage requirements (Title I, Part 6).

The Departments of Labor and the Treasury have responsibility for administering the provisions of Title I and Title II, respectively, of ERISA. The Pension Benefit Guaranty Corporation (PBGC) is responsible for administering Title IV, which established an insurance program for certain benefits provided by specified ERISA pension plans. PWBA meets and coordinates closely with the Internal Revenue Service (IRS) and PBGC on matters concerning pension issues on a regular basis.

In fiscal year 1991, the Department announced its "POWER" proposal—Pension Opportunities for Workers' Expanded Retirement. The proposal seeks to expand

pension coverage, improve pension portability, and simplify the rules for pension plans.

REPORTING AND DISCLOSURE STANDARDS

ERISA requires that plans disclose to participants and report to the Federal Government information about plan provisions and financial status. Each employee benefit plan (unless exempted) must submit an annual report in the form of a financial statement; plans with more than 100 participants must also submit a public accountant's opinion. The annual report generally includes a statement of plan assets and liabilities, a statement of transactions involving conflict of interest situations, and other information regarding the administration of the plan. Annual report forms are simplified for small plans, and a number of paperwork reductions have been instituted since ERISA's enactment in 1974.

The annual report is submitted to the IRS and shared by the ERISA agencies. To assure the filing of complete and accurate annual reports they are subject to an automated review. Under the system the IRS subjects the annual reports to automated edit tests to determine whether all the required information has been supplied. This system gives the Department the capability to systematically identify deficient filings. The information supplied in these reports is used for enforcement and research, and the reports are kept on file for public disclosure. The Pension Protection Act of 1987 amended ERISA to authorize the Labor Department to assess civil penalties of up to \$1,000 per day against plan administrators who fail or refuse to file annual reports. The ability to assess a civil penalty for such failures provides the Department with a necessary tool to effectively enforce ERISA's reporting requirements.

ERISA also requires the plan administrator to provide participants, beneficiaries, and the Department with a summary plan description (SPD) written in plain English. The SPD contains a description of benefits, the requirements for eligibility, and procedures for presenting claims for benefits. In addition, participants may request, and in some cases must be automatically provided with, a statement of their individual benefits.

MINIMUM STANDARDS FOR PARTICIPATION AND VESTING

The IRS, for the most part, enforces the ERISA minimum standards for participation and vesting. ERISA restricts the age and service requirements which plans may impose as conditions of eligibility to participate in an employer's pension plan. The basic rule is that an employee cannot be denied membership in the plan merely on account of age or service, if he or she is at least 21 years old and has worked for the employer for 1 year.

Other ERISA provisions govern when a plan participant must vest, i.e., gain a nonforfeitable right to the portion of the retirement benefit provided by the employer's contributions to the plan. (Amounts attributable to the participant's own contributions are always nonforfeitable.) In this regard, the plan must provide that an employee must vest at a rate which is not less generous than one of the schedules set forth in ERISA. The Tax Reform Act of 1986 established new schedules which, for most plans, provide a nonforfeitable right to retirement benefits sooner than under prior law.

ERISA also contains rules on the rate at which participants must be allowed to "accrue" a benefit, i.e., the rate at which they are considered to have earned a portion of their ultimate retirement benefit. These standards apply to pension plans which promise to provide participants a defined periodic payment upon retirement.

MINIMUM FUNDING STANDARDS

ERISA sets forth rules for financing pension benefits. For plans which promise participants a defined periodic payment upon retirement, the employer's contribution is determined actuarially. Certain assumptions with respect to mortality, interest, and turnover rates are used to calculate how much should be contributed to provide the benefits promised by the plan. ERISA provides rules governing what types of funding methods are appropriate and establishes penalties for failures to comply with these standards. These funding rules are enforced by the IRS. The Department of Labor, however, has jurisdiction over two new disclosure requirements related to the minimum funding standards under the Pension Protection Act of 1987.

FIDUCIARY STANDARDS

ERISA sets forth certain standards regarding the investment and utilization of plan assets with which fiduciaries of employee benefit plans must comply. These

standards include the requirement that plan assets be invested "solely in the interest" of participants and beneficiaries, and that plans be maintained for the exclusive benefit of participants and beneficiaries. ERISA provides that fiduciaries must adhere to standards, in investing plan assets and in administering the plan, which would be followed by a prudent investor. These standards include a standard relating to diversification of plan assets. ERISA also sets forth certain activities that (unless specifically exempted) may not be carried out by certain individuals and groups (including fiduciaries) who, because of the potential for conflict with the interests of the plan, might cause the plan to operate in their own interest. These activities are known as "prohibited transactions," and persons who violate the rules may be subject to an excise tax imposed by the IRS, or a civil penalty assessed by the Department of Labor.

Civil actions may be brought by the Secretary of Labor or by plan participants and beneficiaries for violations of Title I of ERISA. The Department of Labor places great emphasis on enforcing the fiduciary provisions of the Act. In fiscal year 1991, it recovered over \$178 million for employee benefit plans through a combination of litigation and voluntary compliance. Under voluntary compliance breaches of fiduciary duty are corrected through voluntary settlement agreements with plan officials. PWBA also investigates potential criminal violations involving employee benefit plans. Recently there has been an increased emphasis on specialized training in criminal investigative techniques to increase PWBA's capabilities in detecting potential criminal violations. Where investigations uncover criminal violations, referrals are made to the Department of Justice for Prosecution. The Omnibus Budget Reconciliation Act of 1989 created new mandatory civil penalties that apply to recoveries for violations of ERISA by plan fiduciaries.

PLAN TERMINATION INSURANCE

Title IV of ERISA established within the Department a benefit insurance program administered by the Pension Benefit Guaranty Corporation (PBGC), a corporation within the Department of Labor with a Board of Directors consisting of the Secretaries of Labor, Commerce, and the Treasury. This insurance program is applicable only to certain pension plans which promise a defined benefit upon a participant's retirement. Employers who maintain these plans are required to pay an annual per-participant premium to the PBGC to finance this coverage.

The guarantee program differs according to the number of employers maintaining the plan. In the case of a single-employer plan, the PBGC will guarantee, up to prescribed levels, the payment of a participant's nonforfeitable benefit if the plan terminates with insufficient assets to pay these benefits. In the case of a multiemployer plan, the PBGC guarantees benefits up to a prescribed level which is lower than the level guaranteed to single-employer plans. In this case, it is the inability of the plan to pay participants their guaranteed amounts, not plan termination, that triggers financial assistance.

RESEARCH AND DEVELOPMENT

PWBA conducts a coordinated program of research through contracts and in-house studies. The research program develops data on employee benefit plans, which can be used as the basis for program modifications or policy decisions. It also analyzes economic issues related to retirement decisions and income and to the performance and effect of private pension plans in financial markets. The following study areas were reviewed in fiscal year 1990:

- (1) Pension portability and labor market efficiency.
- (2) Women and pension portability.
- (3) Analysis of loss to participants through lump sum pension payouts.
- (4) Costs of mandated health care initiatives.
- (5) Expected health care utilization of the currently uninsured.
- (6) Job transition effect on health care coverage.
- (7) The effect of mandated benefits on the labor market.
- (8) Analysis of trends in administrative expenses of pension plans.
- (9) Study of Multiple Employer Welfare Arrangements and Multiple Employer Trusts participation.

INQUIRIES

PWBA publishes literature and audio-visual materials which explain in some depth provisions of ERISA, procedures for plans to ensure compliance with the Act, and the rights and protections afforded participants and beneficiaries under the law. In addition, PWBA maintains a public information and assistance program

which responds to many inquiries from older workers and retirees seeking assistance in collecting benefits and obtaining information about ERISA. In fiscal year 1991, the national office staff responded to over 73,000 plan participants, beneficiaries, and other persons interested in the administration of plans and recovered over \$6.7 million for plan participants and beneficiaries. Over 81,145 additional inquiries were handled by PWBA's 15 field offices. Among the publications disseminated, the following are designed exclusively to assist the public in understanding the law and how their pension and health plans operate:

- Health Benefits Under the Consolidated Omnibus Budget Reconciliation Act (COBRA).
- What You Should Know About the Pension And Welfare Law.
- Know Your Pension Plan.
- How To File A Claim For Benefits.
- Often Asked Questions About ERISA.
- How To Obtain Employee Benefit Documents From the Labor Department.
- Simplified Employee Pensions: What Small Business Needs To Know.

BUREAU OF LABOR STATISTICS

The Department of Labor's Bureau of Labor Statistics (BLS) regularly issues a wide variety of statistics on the employment situation by age. Monthly data are available on employment and unemployment for older persons, and annual data are available on consumer expenditures for this group.

ITEM 11. DEPARTMENT OF STATE

JANUARY 9, 1991.

DEAR SENATOR PRYOR: In response to your letter of October 2, 1991, I am pleased to enclose the Department of State contribution to your Committee's annual report, *Developments in Aging*. We appreciate the opportunity to have provided input on this subject.

Sincerely,

JANET G. MULLINS,
Assistant Secretary, Legislative Affairs.

Enclosure: a/s.

DEPARTMENT OF STATE REPORT ON DEVELOPMENTS IN AGING IN 1991

The Department of State provides a range of services to aging citizens. Many older Americans travel abroad. The Department issues them passports, keeps them and the travel industry abreast of unsettled overseas conditions by issuing timely "travel advisories," and assists them with special consular services when the need arises while they are traveling. Through its embassies, the Department also aids in the distribution of Social Security benefits to recipients living overseas and assists them in other dealings with the Federal Government.

Older Americans and their organizations constitute an important audience for the foreign affairs conferences and briefings as well as the publications/information provided by the Department. In particular, the Department has maintained a regular dialogue in recent years with AARP, the largest organization of senior citizens. In 1991, the Department scheduled three major events with AARP: a special briefing and reception for the Board of Directors focusing on Eastern Europe and Africa, a special briefing and brunch focusing on U.S.-Soviet relations for approximately 120 presidents and executive directors of national women's organizations, and a country briefing on China for the AARP Director of National Retired Teacher's Activities prior to her travel to China where she addressed a conference sponsored by the Chinese Education Association for International Exchange. Moreover, many older citizens visit the Department each year to take guided tours of its diplomatic reception rooms.

The Department provides various services and benefits to its own older employees and former employees. Employees have the opportunity to take a 1-week retirement planning seminar when they approach the minimum retirement age. They may also take a career transition program immediately before retirement. The Department administers two retirement systems, the Foreign Service Retirement and Disability System and the Foreign Service Pension System, which provide annuities and survivors' benefits to retired members of the Foreign Service and their families. It also organizes an annual 1-day conference for former employees known as Foreign Service Day. Nearly 1,000 Foreign Service retirees and their guests attended Foreign

Service Day on May 3, 1991 to be briefed on current foreign policy issues and keep up their personal contacts with Department officials and each other.

ITEM 12. U.S. DEPARTMENT OF TRANSPORTATION

DECEMBER 20, 1991.

DEAR SENATOR PRYOR: I am pleased to forward to you the enclosed report which summarizes significant actions taken by this Department during 1991 to improve transportation facilities and services for older Americans. The report is being forwarded in response to your letter to Secretary Skinner, requesting information for Part 2 of the Committee's annual report, *Developments in Aging*. I hope you will find this information helpful.

If we can assist you further, please let us know.

Sincerely,

JEFFREY N. SHANE,
Assistant Secretary for Policy and International Affairs.

Enclosure.

SUMMARY OF ACTIVITIES TO IMPROVE TRANSPORTATION SERVICES FOR THE ELDERLY¹

INTRODUCTION

The following is a summary of significant actions taken by the U.S. Department of Transportation during calendar year 1991 to improve transportation for elderly persons.²

POLICIES

FEDERAL RAILROAD ADMINISTRATION (FRA)

The National Railroad Passenger Corporation (Amtrak)³ continued throughout calendar year 1991 its systemwide policy of offering to persons with disabilities and elderly persons a 25-percent discount on one-way ticket purchases. Senior citizens and passengers with disabilities are not permitted to combine their 25-percent discount with any other discounts.

With appropriate prior notification to its reservation office, Amtrak continued to provide special food service, facilities for handling reservations for hearing impaired persons, special equipment handling, and provision of wheelchairs and assistance in boarding and deboarding passengers needing such assistance. Amtrak operates a Special Services Desk 7 days a week that assists special needs passengers with tickets and transportation. Persons may request special services by contacting the Special Service Desk at 1-800-USA-RAIL. They may also inform the travel agent or the station ticket agent of their need at the time they book their travel reservations or call the railroad station in advance of their travel.

More than 125,000 mobility-impaired and other disabled individuals sought assistance from the Special Services Desk last year and tens of thousands of other disabled and elderly persons traveled on Amtrak unassisted. Over the past several years, 28 percent of long-distance passengers were 65 and older. Amtrak works each year with a number of organizations on large special moves of passengers needing assistance.

Amtrak has modified its older coaches and sleeping cars and has incorporated accessibility features in rest rooms and in other areas. Virtually every car can accommodate one electric wheelchair, and Amtrak offers sleeping accommodations on all overnight trains for persons with disabilities. The corporation has replaced battery-operated lifts with mechanical lifts, which are easier to operate and present fewer maintenance problems. It is continuing to incorporate accessibility features in its more than 500 stations as they are upgraded.

¹ Prepared for the U.S. Senate Special Committee on Aging—December 1991.

² Many of the activities highlighted in this report are directed toward the needs of handicapped persons. However, one-third of the elderly are handicapped and thus will be major beneficiaries of these activities.

³ Amtrak operates as an independent entity. However, the Department influences management of the Corporation by its representation on the board and the significant financial support provided through FRA. We have, therefore, incorporated Amtrak's services which benefit senior citizens in the Department's report to the Committee.

Amtrak has improved training of its employees so that they are familiar with the appropriate ways to respond to passengers with special needs.

URBAN MASS TRANSPORTATION ADMINISTRATION (UMTA)

UMTA continued to serve as the lead agency in an interdepartmental working relationship between the Department of Transportation (DOT) and the Department of Health and Human Services (HHS). Under the terms of the interagency agreement, a staff working group has been established, and a formal executive level DOT/HHS Transportation Coordination Council has been formed. The Council, which meets biannually, has directed that regional initiatives be undertaken in each Federal region. Federal regional staff from both Departments have worked with State program administrators to identify barriers to coordination in federally supported programs and to encourage State and local efforts to coordinate funding for specialized transportation services. The liaison between these two Departments will increase the mobility of elderly Americans by improving the coordination and effective use of transportation resources of both Departments.

As a part of its efforts in the Joint Council on Coordination, UMTA and the HHS developed a "Manual of Best Practices" in transportation coordination. This manual covers State and local programs which address barriers to coordination identified through regional initiatives.

Under the activities of the Council, the Administration on Aging (AOA) and UMTA are developing a Volunteer Van Transportation Program for Native Americans who do not live on reservations. This joint program will provide vans, insurance, and maintenance of vehicles for a period of 4 years to develop a community-based transportation program where no public transportation exists.

UMTA and HHS continued to work with the Federal Region IV Transportation Consortium. The consortium is an eight State cooperative effort in Region IV designed to achieve improvements in human service transportation delivery. Project components include development of a coordinated technical assistance mechanism among the member States; research; and identification, and removal of programmatic and institutional barriers to coordinated human service transportation funded by the two Departments. Particular attention is given to transportation and human service programs administered at the State level.

CAPITAL AND OPERATING ASSISTANCE

URBAN MASS TRANSPORTATION ADMINISTRATION

Under Section 16(b)(2) of the Urban Mass Transportation Act, UMTA provides assistance to private nonprofit organizations for the provision of transportation services for elderly persons and persons with disabilities. In 1991, over \$34.8 million was used to assist in the purchase of 1,348 vehicles for the provision of transportation services for these persons. Besides providing transportation service to elderly and disabled individuals, vehicles purchased with 16(b)(2) funds may also be used for meal delivery to homebound persons, as long as this purpose does not interfere with the primary purpose of the vehicles.

Under Section 18 of the Urban Mass Transportation Act, UMTA obligated \$83.8 million to States in 1991. 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. There is a high proportion of elderly persons in these areas.

Under Section 9 of the Urban Mass Transportation Act, UMTA obligated \$1,791.4 million in 1991. 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, a significant number of passengers served are elderly persons.

RESEARCH AND TECHNICAL ASSISTANCE

URBAN MASS TRANSPORTATION ADMINISTRATION

The Rural Transit Assistance Program (RTAP), in its fourth year, was authorized to expend \$5 million in FY 1991. The program provides funding for training, technical assistance, and research, and related support activities in rural areas. States receive 85 percent of the funding, while the remaining 15 percent is allocated to the RTAP National Program. The RTAP National Program supports, among other initiatives, a National RTAP Resource Center RTAP Bulletin, regional outreach initia-

tives, and a 15 member Review Board which provides oversight of the training modules. The RTAP Program produces a wide range of initiatives for elderly persons and individuals with disabilities living in rural areas.

The National Easter Seal Society Project Action (Accessible Community Transportation in our Nation) is a \$3 million research and demonstration grant program now in the final implementation phase. National and local organizations representing public transit operators, the transit industry, and persons with disabilities are involved with the development and demonstration grant program. National and local organizations representing public transit operators, the transit industry, and persons with disabilities are involved with the development and demonstration of workable approaches to promote access to public-transportation services for people with disabilities. There is a large number of elderly among persons with disabilities who will benefit from this project. Project Action has identified five priority areas:

1. Clarify disability problems in the community;
2. Outreach and marketing strategies for people with disabilities;
3. Training programs for transit providers;
4. Training programs for persons with disabilities; and
5. Technology to solve critical barriers to transportation and accessibility.

Project Action is supporting 25 projects within the five priority areas.

Project Action will also assist in the implementation of the Americans with Disabilities Act by investigating what training is necessary to sensitize transit drivers to the needs of people with various disabilities. Tie-down and securement difficulties, especially for the three-wheeled motorized wheelchairs, have been identified for research. Project Action has also identified for refinement and replication throughout the country the "Red Mitt" program instituted by the Southeastern Michigan Area Rapid Transit District (SMART). This program allows persons with disabilities to board a bus by merely holding up their hand with a red mitt. It does not matter whether the transit rider is at a bus stop or not. People can wait at the end of a driveway and can be picked up by a SMART bus. Project Action has also targeted other model projects to be refined and replicated throughout the country. In FY 1992, Congress has mandated an additional \$2 million to continue this program.

FEDERAL HIGHWAY ADMINISTRATION (FHWA)

Work continued on the following FHWA supported studies during 1991:

Traffic Maneuver Problems of Drivers with Diminished Capacity is employing simulator and field methods in an empiric investigation of maneuvers that appear to cause difficulties for older drivers. The study will recommend changes to highway design to mitigate the difficulties.

Relative Visibility of Increased Legend Size vs. Brighter Materials is studying the effects of highly retroreflective sheeting on current stroke-width standards; comparing older driver responses to these brighter signs as compared with their responses to larger signs; evaluating other legend characteristics (font, spacing, and capitalization); and will make recommendations on standards for text signs.

Older Driver Perception-Reaction Time for Intersection Sight Distance and Object Detection is evaluating the perception-reaction time of older drivers in a variety of intersection, stopping, and design sight-distance situations. The report will recommend changes to the perception-reaction time values used in highway design equations and identify alternate models for these equations.

Pavement Markings and Delineation for Older Drivers is using simulator and field techniques to investigate the use of improved pavement marking and delineation systems to enhance their value for older drivers.

Three FHWA-supported studies initiated during fiscal year 1991 are:

Symbol Signing Design for Older Drivers is investigating the use of symbol signs for older drivers, making recommendations on changes to current signs, and developing guidelines for design of future symbol signs.

Traffic Operations Control for Older Drivers is investigating all aspects of intersections (geometrics, signing, signals, and operations) in light of older driver and pedestrian capabilities.

Design Characteristics of Older Adult Pedestrians is using analytical and empirical methods to determine the capabilities and limitations of older pedestrians, and to recommend changes in design to accommodate the population.

The Effect of Saccadic Suppression on Functional Peripheral Vision in Older Drivers, being performed by FHWA staff, is using a part-task driving simulator to investigate the effects of central task load on the ability of older drivers to detect vehicles in adjacent lanes.

FHWA expects to begin four studies during fiscal year 1992. They are:

Intersection Geometric Design for Older Drivers and Pedestrians will investigate geometric needs of older road users at intersections, an area where older drivers experience a large number of accidents.

Investigation of Older Driver Freeway Needs and Capabilities will be a preliminary investigation to assess the extent of older driver usage of, and difficulties with, freeway.

Older Pedestrian Characteristics for Use in Highway Design will develop guidelines, for use by traffic planners and engineers in the design of pedestrian facilities for older persons. The scope will include a determination of the mental and physical capabilities required for pedestrian activities by older persons; a review of information on the capabilities of older persons; identify gaps in information, then design and conduct studies to fill the gaps. The study report will recommend changes in appropriate design standards and operational procedures to accommodate older pedestrians within the highway system.

Traffic Control Device Design and Redundancy to Aid the Older Driver, under the auspices of the National Cooperative Highway Research Program, will investigate, in predominantly field settings, issues related to the design and placement of signs to aid older drivers in terms of detection, comprehension, recognition, and response time.

At present, the FHWA has plans to begin one study in fiscal year 1993:

Synthesis of Research Findings on Older Drivers will review and synthesize all the research findings in the High Priority National Program Area for older driver research, as well as other relevant research, in a format compatible for later inclusion in a driver handbook. Implementation plans will be developed and future research needs identified.

NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION

During 1991, the National Highway Traffic Safety Administration (NHTSA) continued to implement its long-term Traffic Safety Plan for Older Persons, initiated in 1988, to improve the safety of older persons on our Nation's streets and highways. This work includes coordinated research with the private and public sector on older driver safety, occupant protection, and pedestrian safety.

Older Driver Safety

NHTSA is analyzing driving patterns and functional ability data from its cooperative research with the National Institute on Aging (NIA). This program obtained transportation-related data from older persons who averaged 80 years of age and whose medical histories have been followed for 8 years. Analyses indicate that some older people with substantial functional deficits are still driving; however, most appropriately use their medical conditions and functional capabilities to reduce their driving and walking. There is a concurrent reduction in their ability to meet their transportation needs. More detailed data collection and additional analyses are scheduled for 1992, and implications of the findings on the older adult's safety and mobility will be determined.

The Transportation Research Board's (TRB) Task Force on the Safety and Mobility of Older Persons, which NHTSA is chairing, continues to coordinate research and development activities across the private and public sector. It serves a multidisciplinary constituency, directing research attention to currently under-researched areas, helping to avoid unnecessary duplication of effort, and disseminating information about the latest findings in the field. The Task Force has sponsored a number of national and international meetings on the research and development needs pertaining to older drivers and is developing an updated research priorities list and a directory of those interested in the older person transportation issue to be published by the TRB.

Occupant Protection

As people age, their vulnerability to injuries and fatalities increases dramatically. Thus, a growing challenge is the question of how older vehicle occupants can be better cared for when in a crash. The agency is supporting two major activities to better understand and increase the survivability of older vehicle occupants. NHTSA awarded a grant to the Jackson Memorial Hospital in Miami, FL, to develop an Automobile Trauma Care and Research Facility. The grant should facilitate the establishment of an information system that will advance both the delivery of emergency trauma care and the detailed data for research on automobile injuries, treatments, outcomes, and costs. The availability of an older population of automobile

injury victims in the Miami area should provide early insights into the prevention of restrained/unrestrained occupant injuries that will be of increasing national importance as the population ages and the use of occupant restraints (air bags and automatic and manual belts) grows. NHTSA is also providing support to the Department's Volpe National Transportation Systems Center to use math simulation and experimental work to identify possible incompatibilities between current belt/bag systems and older vehicle occupants. Particular attention will be paid to the identification of possible approaches to improve alternate restraint designs or requirements that focus on the needs of older vehicle occupants.

Pedestrian Safety

Older pedestrians, ages 65 and older, have the highest pedestrian death rate of any age group. NHTSA and FHWA initiated a 3-year joint pedestrian safety program in January 1990 to reduce traffic fatalities involving the older pedestrian. The major components of this program are community traffic safety program (CTSP) grants, research and development projects, technology transfer activities, and public information initiatives.

The CTSP grants are an important element of the program. They serve as seed monies to assist communities in including pedestrian safety initiatives in their community programs. During the summer of 1990, seven community grants were awarded as part of the NHTSA/FHWA pedestrian safety program. Another seven grants were awarded in 1991. Most of the grants, which are for a period of 18 to 24 months, have an older pedestrian component. Engineering, enforcement, and education disciplines are prerequisites to finding solutions for older pedestrian safety problems in these projects. Each of the projects meets the specific needs of individual communities. An engineering module, for example, may focus on the timing of traffic signals; an education module may develop informational programs for delivery at senior centers; and an enforcement module may be focused on crosswalk violations by motorists.

NHTSA recently completed its project titled, "Development of Safety Information Materials and Media Plans for Elderly Pedestrians." The project identified the major pedestrian risks facing older (65+) adults and suggested actions they can take to avoid accidents. The risks included turning vehicles, backing accidents, and other intersection accidents. In addition, it was confirmed that accidents involving older people increase markedly in the winter months when the sun angle is lowest. This increase appears to be a problem of conspicuity. Pedestrian safety messages were then developed for each of the four accident situations.

A joint NHTSA/FHWA research project titled, "Development, Implementation and Evaluation of a Pedestrian Safety Zone for Elderly Pedestrians" was initiated in 1990. The project focuses on the idea that countermeasures can best be delivered when the target audience (the older people in this case) congregates for some routine life purpose. This led to the defining of pedestrian safety zones within a city that has a preponderance of older pedestrian accidents and older residents. Saturating such zones with engineering and behavioral countermeasures of known effectiveness may prove to be a more efficient way of preventing older pedestrian accidents than other distribution/application methods. The countermeasures will be drawn from an existing body of safety education and engineering materials. Of particular importance will be the safety advice developed in the above cited project and incorporated into a slides and printed material package called "*Walking Through the Years*." In FY 1992, NHTSA will develop slide and videotape presentations for older pedestrians based on the research. These slides and videotapes will be designed for presentation by State and local safety officials to forums with older groups.

In 1987 NHTSA and FIIWA contracted with the National Safety Council (NSC) to develop a community approach to pedestrian safety issues. The Walk Alert Program was the product of that contract. In 1991 the agencies awarded another grant to the NSC to revise the program and address issues not adequately covered in the first edition. Special attention is being given to elderly pedestrian issues. The revised program will be the focus of a second multiyear joint agency program in pedestrian safety.

The agency will review and, if necessary, update its near-term research agenda in light of recent research initiatives concerning older drivers and pedestrians.

INFORMATION DISSEMINATION

FEDERAL RAILROAD ADMINISTRATION (FRA)

To inform senior citizens and Americans with disabilities about special services and accessible stations, a brochure entitled, "Amtrak Travel Planner" is available in stations, local sales offices, and through travel agencies.

NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION (NHTSA)

During 1991, NHTSA and the National Institute on Aging (NIA) prepared a special edition of the journal "Human Factors" dealing with the older driver. Current status of older driver issues were also presented at meetings of the American Psychological Association, Transportation Research Board, Gerontological Society, the Human Factors Society and at conferences on older drivers convened by NHTSA's Region VII and for the State of Pennsylvania. NHTSA and the California Department of Motor Vehicles helped convene an international conference on Driver Performance Assessment which emphasized older drivers.

The NHTSA-produced pamphlet and set of slides titled, "Walking Through the Years" was distributed to major organizations having large audiences of older persons. The agency is making plans to make the same information available to smaller organizations serving older persons.

NHTSA and FHWA produced a pedestrian resource kit to provide guidance to highway safety officials in developing pedestrian safety programs and strategies. The kit was distributed to all NHTSA regional offices, FHWA regional and divisional offices, and the highway safety offices in each State.

RESEARCH AND SPECIAL PROGRAMS ADMINISTRATION (RSPA)

The Technology Sharing Program, in the Department's RSPA continued to release technical materials dealing with the transportation problems of elderly persons and persons with disabilities. These included the following products:

The *Guidebook for Planning Small Urban and Rural Transportation Programs* is a two-volume manual that provides a comprehensive process for community-scale system planning. Topics particularly important to senior citizens include system coordination, and how to determine equipment and facility needs which reflect the requirements of particular user groups.

The *FY 1991 Vehicle Catalog* summarizes the kinds of small transit vehicles available today, and the ancillary equipment for them, as a guide to specification development. Among the types of ancillary equipment discussed are wheelchair lifts, wheelchair ramps, and wheelchair securement systems.

The *Proceedings of the Ninth National Conference on Rural Public Transportation* covers the full range of topics associated with small city and rural transportation services. Session summaries include material on coordination, private sector contracting, legal issues, vehicle specifications, and insurance, among other topics.

The Technology Sharing program also continued to distribute earlier releases of documents dealing with specialized transportation, including *Coordination of Rural Public Transportation Services in Three Southeastern States* and *Best Practices in Rural and Human Services Transportation Coordination*.

The Department's Technology Sharing Program staff participated in the planning of the most recent National Conference on Specialized Transportation, held in October 1990 and the just-concluded Tenth National Conference on Rural Public Transportation, held in October 1991.

Program staff ran a resource center at both conferences which made available to conference attendees, state-of-the-art technical materials. These resource centers provided a particularly strong validation of the usefulness of the materials, and helped identify future technical products to distribute. Materials made available at national conferences are also supplied to State agencies upon their request for use at state-level training sessions and transportation conferences.

ITEM 13. DEPARTMENT OF THE TREASURY

DECEMBER 13, 1991.

DEAR MR. CHAIRMAN: I am pleased to submit, for inclusion in *Developments in Aging*, the Treasury's report on the Department's activities during 1991 which af-

fects the aged. I hope our report will be of use to the Special Committee on Aging and others studying the problems faced by older Americans.

Sincerely,

MARY C. SOPHOS,
Assistant Secretary (Legislative Affairs).

Enclosures.

TREASURY ACTIVITIES IN FISCAL YEAR 1991 AFFECTING THE AGED

The Treasury Department recognizes the importance and the special concerns of older Americans, a group that will comprise an increasing proportion of the population in decades ahead.

The Secretary of the Treasury is Managing Trustee of the social security trust funds. The short- and long-run financial status of these trust funds is presented in annual reports issued by the Trustees. The 1991 reports concluded that Old-Age and Survivors Insurance and Disability Insurance (OASDI) benefits can be paid on time well into the next century. As reflected in the past several reports, the financial outlook for Medicare, in particular Hospital Insurance (HI), may become troublesome shortly after the turn of the century. Although legislation enacted in late 1990 has provided additional breathing space for the HI Trust Fund, some Congressional action may be required by early in the next century. During 1991, the OASDI cost-of-living increase was 5.4 percent. The taxable base for OASDI was \$53,400, the taxable base for HI was \$125,000, and the amount a 65- to 69-year-old beneficiary could earn before his or her OASDI benefits were reduced was \$9,720 per year.

With respect to the personal income tax, in 1991 the width of the income tax brackets and the sizes of personal exemptions and of the standard deductions were indexed to reflect the effects of inflation of approximately 4.8 percent which occurred during the preceding year. The personal exemption increased by \$100 to \$2,150 for each taxpayer and dependent.

Taxpayers age 65 or over (and taxpayers who are blind) are entitled to larger standard deductions than other taxpayers. For 1991, each taxpayer who is single and who is at least 65 years old is entitled to an extra \$850 standard deduction. Each married taxpayer age 65 or over is entitled to an extra \$650 so that a married couple both of whom are over age 65 are entitled to an extra \$1,300. Including these extra standard deduction amounts and the basic standard deduction amounts, taxpayers over age 65 are entitled to the following standard deductions for tax year 1991: \$4,250 for a "single" taxpayer; \$5,850 for a taxpayer entitled to claim "unmarried head of household" status; \$6,350 for a married couple filing a joint tax return, only one of whom is 65 or older; and \$7,000 for a married couple filing jointly if both are age 65 or older. The corresponding amounts for tax year 1990 were: \$4,050 for a "single" taxpayer; \$5,550 for a taxpayer entitled to claim "unmarried head of household" status; \$6,100 for a married couple filing a joint tax return, only one of whom was 65 or older; and \$6,750 for a married couple filing jointly if both were age 65 or older.

Two other special provisions for the elderly were retained: tax credit for the elderly (and permanently disabled); and the one-time exclusion of the first \$125,000 of profit from the sale of the personal residence of a taxpayer age 55 or older.

INTERNAL REVENUE SERVICE ACTIVITIES AFFECTING THE AGED

The Internal Revenue Service (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. Major programs and initiatives of the Office of the Assistant Commissioner (Taxpayer Services) that are of interest to older Americans and to others are described below.

The following publications, revised on an annual basis, are directed to older Americans:

Publication 523, *Tax Information on Selling Your Home*, sets forth the rules regarding the once in a lifetime exclusion of \$125,000 of the gain on the sale of a personal residence of a person 55 years of age or older.

Publication 524, *Credit for the Elderly or Disabled*, explains that individuals 65 and older are able to take the Credit for the Elderly or Disabled, reducing taxes owed. In addition, individuals under 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, *Tax Information for Older Americans*, explains that single taxpayers age 65 or older are not required to file a federal income tax return unless their gross income for 1991 is \$6,400 or more (as compared to \$5,500 for

single taxpayers under age 65). Married taxpayers who can file a joint return are not required to file unless their joint gross income for 1991 is \$10,650 or more if one of the spouses is 65 or over, or \$11,300 if both spouses are 65 or older.

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 Information for Persons with Handicaps or Disabilities*, covers tax issues of particular interest to persons with handicaps or disabilities and to taxpayers with disabled dependents.

Publication 915, *Social Security Benefits and Equivalent Railroad Retirement Benefits*, assists taxpayers in determining the taxability, if any, of benefits received from Social Security and Tier I Railroad Retirement.

All publications are available free of charge. They can be obtained by using the order forms found in the tax forms packages and in Publication 910, or by calling 1-800-TAX-FORM (1-800-829-3676). Many libraries, banks and post offices stock the most 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. Outreach programs include:

The *Tax Counseling for the Elderly (TCE) Program*, which provides free tax assistance to persons 60 and older. The IRS enters into cooperative agreements with public and private nonprofit organizations (sponsors) whose members will be trained by IRS to act as volunteer tax assistants at selected sites identified by the sponsors. Sponsors also now have the option to operate telephone answering sites to assist the elderly with tax questions, help with forms, or schedule appointments. IRS assistance to older Americans through the TCE program has been growing since the program began in 1980. Nearly 29,000 volunteers helped 1.5 million persons during the past filing period.

The *Volunteer Income Tax Assistance (VITA) Program* provides tax assistance to targeted groups including low income persons, non-English speaking persons, and the elderly. The IRS trains volunteers who offer their services to taxpayers needing assistance. This service is free and many VITA volunteers also help the elderly in preparing their state and local returns and answering their questions. In addition, volunteers helped elderly taxpayers compute their estimated tax for the current tax year. New and enhanced training for volunteers will be available in 1991. The new training was developed in response to a study that included evaluations by educational authorities and surveys of volunteers and IRS employees involved in VITA and TCE.

The *Small Business Tax Education (STEP) Program* provides information about business taxes and the responsibilities of operating a small business. Through a partnership between IRS and about 1,800 community colleges, universities, and business associations, small business owners and other self-employed persons have an opportunity to learn what they need to know about business taxes. Assistance is offered at convenient community locations and times. Many elderly persons, such as those beginning second careers, avail themselves of this program.

As part of the *Banks, Post Offices, and Libraries (BPOL) Programs*, the IRS supplies 12,000 libraries with free tax aids such as reproducible tax forms, reference publications, and audio-visual materials that can assist older Americans in preparing Forms 1040EZ, 1040A, 1040 and related schedules. Also, banks and post offices distribute the Form 1040 family and other forms.

The *Community Outreach Tax Education Program* provides individuals with group income tax return preparation assistance and tax education seminars. IRS employees and trained volunteers conduct these seminars that address a variety of topics. They are tailored for groups and individuals with common tax interests, such as groups of older Americans. These seminars are conducted at convenient community locations.

The 1990 tax year was the first year older Americans could use the expanded Form 1040A to report income from pensions and annuities, as well as other items applicable to older Americans such as estimated tax payments and the credit for the elderly or the disabled. More than half of the potential filing population eligible to use this simpler, shorter form rather than the much longer Form 1040 made the switch.

Responding to requests from the public for such a product, the Tax forms and Publications Division developed large-print versions of the Form 1040 and Form 1040A packages earmarked for older Americans. These packages (designated as Publications 1614 and 1615, respectively) are newspaper-size and contain both the in-

structions and the forms (for use only as worksheets, with the amounts to be transferred to regular-size forms for filing).

The tax Forms and Publications Division reviews annually two publications for Congress. These are *Protecting Older Americans Against Overpayment of Income Taxes*, from the Senate Special Committee on Aging, and *Federal Income Tax Guide for Older Americans*.

OTHER TREASURY ACTIVITIES AFFECTING THE AGED

Other agencies of the Treasury also have an impact on the elderly as part of their specific functions. Developments during 1991 are summarized below:

The Financial Management Service continued to promote the benefits of Direct Deposit through Direct Mail advertising. During fiscal year 1991, the Financial Management Service enclosed inserts with recurring benefit checks (e.g., Civil Service Retirement, Veteran Affairs Compensation/Pension, Social Security), and a Direct Deposit promotional message appeared on the back of check envelopes. Check inserts and check envelope messages serve as marketing aids to promote the convenience, safety, and reliability of depositing Government payments into personal checking or savings accounts by using Direct Deposit.

The Financial Management Service continued to support the Social Security Administration's Direct Deposit enrollment initiative by developing and distributing specific promotional materials for the Social Security Administration's district offices and financial institutions nationwide. The district offices and financial institutions, in turn, provided these materials to benefit recipients.

A feasibility study of Automated Direct Deposit Enrollments was completed by the Financial Management Service and the Social Security Administration. The study examined the feasibility of financial institutions electronically enrolling the Social Security Administration's benefit recipients in Direct Deposit. The study concluded that Automated Enrollments reduced the time period for enrollments by 1 month, made the first Direct Deposit payment date more predictable and reduced enrollment errors. This program makes enrolling in Direct Deposit more attractive to senior citizens. As a result, the Financial Management Service is planning to expand the program during 1992.

The Financial Management Service is working with the National Automated Clearinghouse Association's (NACHA) Addenda Records Task Force on the use of ACH addenda records to pass payment-related information (e.g., to transmit cost-of-living adjustment notices or adjustments to tax refunds along with the Direct Deposit payments) to consumers, including elderly recipients. Participation in such efforts will permit the Financial Management Service to influence industry standards and provide greater assurance that the needs of elderly taxpayers and the Government will be met.

The Financial Management Service has been designated by the Office of Management and Budget as the lead agency in developing Electronic Benefit Transfer (EBT) for Federal agencies. EBT is a program designed to improve and modernize the current delivery system of benefit payments. EBT provides recipients with an alternative to paper checks and allows them to access their funds immediately using a single plastic debit card and modern electronic technology. The Financial Management Service and Social Security Administration completed the first test to distribute Federal benefits to those recipients without bank accounts using EBT last October 31, 1991. This 1-year test was successful in safely and efficiently delivering payments to Supplemental Security Income recipients in Baltimore, MD. In focus groups conducted at the conclusion of the test, recipients state that they were extremely happy with the program and its enhanced service.

A second pilot is currently underway in Harris County (Houston), Texas which provides Social Security and Supplemental Security Income recipients with a plastic card to receive their benefits through the PULSE network of Automated Teller Machines (ATMs) and Point of Sale (POS) terminals located in grocery and other retail stores. The pilot, originally scheduled to run for 12 months, will be extended for at least another 2 years. During this time, the pilot will be expanded to include enrolling additional benefit recipients into the program and issuing multiple direct Federal payments on a single access card. In coordination with other Federal agencies, the Financial Management Service will also be pursuing the possibility of combining Federal and State payments on one card and developing governmentwide standards to promote the use of EBT.

It is estimated that there are approximately 8 million individuals receiving Federal benefit payments each month who do not have bank accounts. Issuing these payments electronically will save the Government millions of dollars annually and eliminate claims for lost, stolen, or misplaced checks. There is also a tremendous social savings to be realized. Annually, recipients pay approximately \$325 million to cash their checks.

Throughout fiscal year 1991 the U.S. Savings Bonds Division continued its program providing important information about Bonds to various segments of the public, including older citizens. The program included advising the news media, financial institutions, employers and major national organizations—such as the American Association of Retired Persons—of the current interest rates, tax implications, exchange privileges, and maturity status of Bonds, particularly those purchased during the 1940's and 1950's. Updated promotional materials and public service advertising contained special references to the benefits of saving for retirement by investing in Savings Bonds. The Division also provided easy-to-access information via a toll-free telephone service, and easy-to-purchase mail ordering via IRS refund checks that contributed to Bond sales that totaled \$9.15 billion for FY 1991. As of September 30, 1991, the total value of Savings Bonds held by Americans was \$135.37 billion.

The Bureau of the Public Debt continues to make improvements in programs to better serve all investors. The Bureau's efforts to streamline and simplify access to Treasury securities are of particular benefit to elderly investors.

MARKETABLE SECURITIES

Book Entry Conversion.—Public Debt continued its efforts to encourage owners of registered Treasury securities to convert their paper certificates to book-entry form. In March 1991, Public Debt wrote to owners of registered Treasury securities to encourage them to convert their certificates to book-entry form in TREASURY DIRECT or at financial institutions or broker/dealers in the commercial system. Converting to book-entry eliminates the need for safekeeping these readily transferable securities.

Matured Unredeemed Securities.—Public Debt is making significant progress in locating investors owning matured registered securities which have not been presented for payment. Once located, these investors are reminded that they hold matured securities, that the securities are not paying interest, and where the securities can be presented for payment. Those investors who cannot locate their securities are advised to file a claim with Public Debt. Public Debt has recently honored more than \$1 million in claims. This initiative continues to assist elderly individuals in redeeming their lost or forgotten securities.

Streamlined Claims Procedure.—In September 1991, Public Debt eliminated the corporate surety or the two individual sureties requirement on bonds of indemnity on claims for relief involving lost, stolen, or destroyed registered securities when certain conditions are met. The new requirement of a single bond of indemnity has made processing claims faster and eliminated the difficulty investors were experiencing in trying to obtain either corporate surety or two individual sureties. This simpler procedure benefits all securities owners, particularly the elderly.

Treasury Information Center.—In October 1991, as a service to "walk-in" customers, Public Debt's Securities Transaction Branch installed an easy to use computer system.

The Treasury Information Center provides easy access to information about bonds and securities through the use of a touch sensitive computer monitor. The user friendly program allows the customer to use the Treasury Information Center simply by touching the computer terminal. The system provides a variety of information, such as a schedule of upcoming offerings, recent auction results; how to buy bills, notes and bonds; instructions for filling out forms; information on interest payments and taxes; and directions for buying and cashing savings bonds.

This system assists elderly customers by providing detailed easy-to-read answers to the most frequently asked questions. Also, investors can view the information at their leisure.

SAVINGS BOND PROGRAM

Forms Simplification.—The Savings Bond Operations Office (SBOO) is continuing its efforts to revise and simplify savings bond forms. Various forms have been redone, or are in the revision process, to make them easier to read, understand and complete. The simplification of these forms will benefit the elderly.

Undeliverable interest.—Public Debt is taking aggressive action to disburse undeliverable interest being held on deposit. We have established an operating unit specifically designed to locate persons entitled to Series HH/H interest payments that have been returned as undeliverable. In fiscal year 1991, our Locator Group released \$2.6 million in interest. This activity benefits all current income bond owners, many of whom are elderly.

Series HH/H Automation.—A new Series HH/H Bond System was implemented in April 1991. This fully automated system provides for improved processing efficiency and payments controls, and utilizes the Federal Reserve telecommunications network for on-line processing of issue, reissue, redemption, and exchange transactions. Public Debt is able to dramatically improve service to current income bond holders, many of whom are elderly. The exchange of Series EE/E bonds, which offers bond owners the option of deferring tax liabilities for accrued EE/E bond interest, continues to be an attractive feature of the Savings Bond Program for older investors.

Regional Delivery System (RDS).—With RDS, investors purchase bonds through their financial institutions and the bonds are issued and mailed from the Federal Reserve Bank. RDS does not affect investor earnings as the bond's issue date continues to be based on the month in which payment is made to the financial institution. Gift certificates are provided for those who buy bonds as gifts for special occasions. Investors receive their savings bonds within 3 weeks of making their purchases. Investor acceptance of RDS has been exceptionally rapid and positive.

RDS makes it possible for Treasury to achieve its goals of modernizing and strengthening the savings bond program. Treasury will realize substantial administrative and cash management savings, making it possible to continue offering a low-priced security to savers at more than 40,000 convenient locations nationwide. Savings bonds are the most widely held security because they provide a savings medium for small investors at an attractive rate. With a purchase price as low as \$50, savings bonds are within reach of all savers, particularly the elderly.

The Office of Consumer Affairs serves as the liaison between the Department of the Treasury and individual senior citizens and senior citizen organizations, assisting them with referrals to the offices or bureaus which can best answer their inquiries or solve their problems. This office provides the opportunity for representatives from aging organizations to participate in meetings regarding Treasury legislative proposals.

During 1991, the Office of the Comptroller of the Currency (OCC) continued its active liaison with national organizations representing bank customers, including the American Association of Retired Persons, to share information about banking related issues. OCC district offices continued their outreach programs for purposes of contacting and meeting with local consumer and community groups to share information about banking related issues. Organizations representing the elderly were among those contacted. Additionally, OCC distributed 11 banking issuances to over 1,200 consumer and community groups throughout the United States including those representing the elderly.

In May 1991 the OCC distributed a publication, *Leveraging Bank Resources for Low- and Moderate-Income Housing*, to all national banks, bank trade associations and bank customer groups, including those representing the elderly. Affordable housing has been an issue of concern voiced by the American Association of Retired Persons in meetings with the OCC. The publication provides guidance to bankers on innovative programs banks can utilize in partnership with community organizations, as well as federal, state and local governments to finance low- and moderate-income housing. The goal of these programs is to increase the supply of affordable housing for low- and moderate-income persons, including the elderly.

The OCC also is responsible for resolving complaints against national banks. Through the first ten months of 1991, the OCC received over 12,500 complaints. Older Americans seek OCC's assistance in resolving problems with their bank.

The Treasury Department continued to protect elderly recipients of Government payments through the vigilance of the Secret Service. During Fiscal Year 1991, the Secret Service closed 43,808 Social Security check investigations. In addition, the Secret Service closed 3,615 check investigations involving Veterans' benefits, 1,148 involving Railroad Retirement checks, and 1,538 involving Office of Personnel Management checks. The majority of these checks were issued to retirees.

The Secret Service also conducted over 6,394 investigations involving attempts by individuals to illegally divert funds during the direct deposit/electronic funds transfer process. Elderly Americans have been encouraged to utilize the electronic transfer process as a matter of convenience and as a safeguard against the loss of funds.

The Bureau of Engraving and Printing continued to recognize the special needs of aging citizens during 1991. Services to assist senior citizens who tour the Bureau's visitor center include:

The Bureau provides CPR training on an ongoing basis to its tour, medical, and police units in the event that an emergency should occur.

The Bureau has wheelchairs available for senior citizens touring the facility, as well as tour guides trained to assist senior citizens with special needs.

The Bureau has constructed ramps, wide entrances, and restrooms designed to accommodate persons using wheelchairs or walkers.

With respect to Bureau employees:

The Bureau periodically conducts a Pre-retirement Program for employees 50 years of age and over. The Program, also available to spouses, emphasizes the importance of planning for retirement in advance. It is offered to employees who are planning to retire within the next 5 years, and covers such areas as calculation of benefits, financial planning, discovering hidden talents, legal affairs, relationships and health.

The Bureau's on-site medical staff provides life-style counseling for employees who are senior citizens. The emphasis is on wellness, prevention of disease, and includes advice on nutrition and weight control, testing of blood pressure and cholesterol level, and examination of possible vision and hearing deficiencies.

The Customs Services does not specifically target the aged for expedited Customs processing. However, the aged are included among those who are entitled to request special treatment when they arrive from abroad. Besides the elderly, that group includes persons who are handicapped or ill and are unable to wait in line, a parent arriving with several infants, and persons returning home for emergency reasons such as a death in the family. Any traveler meeting any of the above criteria may request to speak with a Customs supervisor as soon as he or she arrives in the Customs area of the airport or other Customs port of arrival. The supervisor will provide all possible assistance in expediting the traveler's Customs clearance without, of course, compromising Customs enforcement responsibilities.

In addition, customs works with the General Services Administration and local port authorities to insure that inspection facilities, including restrooms, permit the easy movement of persons who must use a wheelchair or walker.

Customs places a high priority on the tactful and courteous treatment of travelers. Although that policy is not limited to our treatment of the elderly, it may be of particular importance to people who have found it difficult to undergo a long, tiring flight from overseas and then must undergo immigration and customs processing.

The United States Mint continues to consider the special needs of senior citizens in its programs and services. Special accommodations for elderly visitors are available at the Mint facilities (Philadelphia Mint, Denver Mint, and San Francisco Old Mint Museum) that offer public tour programs. Most significant of these programs during Fiscal year 1991 was the opening of the new Visitors Center at the Denver Mint. The Visitors Center includes elevators for elderly visitors that provide access to the mezzanine level for guided tours. In addition, the tour route is carpeted to ease the strain of walking while enjoying the tour.

The Bureau of Alcohol, Tobacco and Firearms has activated a community involvement program called Project Outreach. The program began functioning in May 1990 as a public awareness project designed to inform the public of the growing threat of street gang violence. The information is presented to civic groups as well as local community anti-drug educational organizations.

Pre-Retirement Programs are offered to employees within three years of retirement. Various information is presented through this program including financial planning, retirement benefits and health and legal affairs.

The Health Improvement Program provides life-style counseling for employees who are senior citizens. The program emphasizes wellness, prevention of disease, nutrition and weight control advice, blood pressure and cholesterol testing and examination of possible vision and hearing problems.

Several organizations within Treasury's Office of Management have been involved in activities affecting older persons during fiscal year 1991. The organizations and activities are as follows:

The Printing and Graphics Division is implementing procedures to add increased security to government checks through the introduction of Watermark Safety Paper in the production of U.S. Government checks. The increased security features will benefit elderly Americans as well as all other recipients of government checks.

The Office of the Curator's public tour program is very popular with older citizens. The tour program is conducted every other Saturday with three tours

in the morning beginning at 10 a.m. The tours are conducted by Treasury volunteer docents and are free. Since individuals are required to give their birthdate and social security number to qualify for the tour, the office has been able to ascertain the popularity of the tour with senior citizens.

The Office of Personnel Policy, in conjunction with the Social Security Administration and the Office of Personnel Management, prepared guidance concerning certain reductions to Social Security and other retirement benefits. The material will be helpful to employees who are approaching retirement and wish to estimate their entitlements under Social Security and Civil Service Retirement.

ITEM 14. ACTION

DECEMBER 9, 1991.

DEAR MR. CHAIRMAN: Thank you for your letter of October 2, 1991, requesting ACTION's report on our 1991 accomplishments for Volume II of the Senate Special Committee on Aging's annual report, *Developments in Aging*.

FY 1991 was another very successful year for ACTION's Older American Volunteer Programs—Retired Senior Volunteer Program (RSVP); Foster Grandparent Program (FGP); and Senior Companion Program (SCP).

In FY 1991, ACTION successfully worked with a number of public and private sector agencies and organizations to enhance both financial and non-financial support for all three programs. The efforts resulted in new and continuing agreements with national organizations to implement new components and provide the services of additional volunteers.

As indicated in the enclosed report, 1991 saw more than 460,000 senior volunteers supported by ACTION programs continuing to make an important contribution to their communities and the Nation.

I sincerely appreciate the opportunity to submit the FY 1991 report on ACTION's Older American Volunteer Programs.

Sincerely,

JANE A. KENNY,
Director

Enclosure.

RETIRED SENIOR VOLUNTEER PROGRAM IN FY 1991

In FY 1991, with a budget of \$33.4 million, the Retired Senior Volunteer Program (RSVP) completed its 20th successful year. There were 746 ACTION-funded projects and 13 non-ACTION funded RSVP projects with over 427,000 volunteers assigned to 55,700 community agencies nationwide, providing over 76 million hours of service. RSVP volunteers serve in courts, schools, museums, libraries, hospices, hospitals, nursing homes, and a wide range of other public and private non-profit organizations. Volunteers serve without compensation, but may be reimbursed for, or provided with, transportation and other out-of-pocket expenses. All volunteers are covered by appropriate accident and liability insurance coverage.

The program continues to expand its efforts to match resources to the diverse needs of hundreds of American communities by providing increased opportunities for retired persons 60 years of age and older to serve their communities on a regular basis in a variety of settings. ACTION's current RSVP projects emphasize intergenerational activities, especially with "at-risk" youth, literacy, substance abuse, and in-home care.

In FY 1991, ACTION completed the first year of a 3-year initiative to increase the number of RSVP volunteers involved in drug abuse prevention and education, including a public information and awareness component addressing prevention of prescription and over-the-counter medications misuse by seniors.

A total of 117 projects received "Programs of National Significance" awards totaling \$656,751. These awards will support an additional 3,601 new volunteers serving in 10 specific program areas. These areas include intergenerational activity, literacy, mentoring, and services to persons with chronic and debilitating illnesses.

ACTION-funded projects received augmentations of approximately 4.17 percent to provide some relief from inflationary increases in administrative cost items. Augmentations totalling \$1,299,751.

During 1991, Research Triangle, Inc., under contract to ACTION, conducted an evaluation of RSVP volunteer involvement in the area of drug abuse prevention and education. The final report will be available in early 1992.

PROJECT EXAMPLES

Arkansas.—Intergenerational Drug and Alcohol Abuse Education/Prevention.

The Arkansas affiliated chapter of the National Federation of Parents for Drug-Free Youth, a VISTA sponsor, provided training in methods of drug prevention education to all 13 RSVP projects on June 26, 1991, in Little Rock. VISTA volunteers helped to conduct this training.

All RSVP project directors and most project volunteer coordinators participated in the training. The emphasis of the training was prevention/education through schools and community-based organizations. It included various techniques of organizing and use of communications to support the community education process. More than 500 RSVP volunteers are now serving in substance abuse components statewide in all 13 RSVP projects.

Hopkinsville, KY.—The College for Living Program of the Pennyrile RSVP in Hopkinsville, KY, merges the skills of RSVP volunteers with programs for developmentally delayed adults. The program extends throughout three counties through the Hopkinsville and Madisonville Community Colleges and the Muhlenberg County Opportunity Center, in conjunction with the Pennyrile Mental Health Center. The colleges offer courses specifically designed to assist disabled adults to become more independent in daily living. Courses such as job readiness, calculator math, microwave cooking, sewing, and first aid use RSVP volunteers to assist with classes and provide additional support for cultural enrichment, recreation, and transportation. Seventy-five adult students were assisted and graduated from the first class.

The program had instant community recognition and success. For example, after the first class graduated in July 1991, students from the two local colleges offered to host and manage the graduation ceremony in 1992. Volunteers from local businesses were loaned during the workday to teach or assist with some of the classes. Olsten/UpJohn Healthcare Services, for example, loaned local administrators to teach first aid, including the appropriate use of drugs and emergency responses related to misuse.

In addition, the Christian and Hopkins County school systems initiated a special curriculum covering child care and home economics for teenage mothers and pregnant women. RSVP volunteers assist with these classes as well. The project is sponsored by the Pennyrile Allied Community Services, Inc.

Hillsboro, OR.—The Washington County RSVP in Hillsboro, OR, sponsored by the Washington County Agency on Aging, has developed a mentoring program in conjunction with the county school system. The program, Senior Members in Learning and Educational Services (SMILES), is designed both to support the mentees' educational possibilities and to strengthen the family and intergenerational bonding for "at risk" youth. The SMILES Director, a retired pediatric dentist, is a former RSVP volunteer.

During the first year, mentors worked with students from one junior high school district. Mentors provided educational support, cultural enrichment activities, and visits and activities for mentees with their families.

The program plans to expand its focus in the following areas during the next 2 years:

- (a) To increase the mentoring involvement with Hispanic youth from the migrant stream out of Texas;
- (b) To improve the focus on substance abuse problems;
- (c) To increase the focus on socialization;
- (d) To add an additional intergenerational element to the program so that other youth can serve seniors. For example, assigning youth to work on a life history project with residents of a nursing home; and
- (e) To expand the SMILES program into three other county school districts.

NON-ACTION SUPPORT

Projects have successfully generated non-ACTION resources to help expand and improve volunteer services. RSVP sponsors, their advisory councils and staff, have used imaginative and varied approaches to attract cash and in-kind contributions. RSVP's total non-ACTION support was over \$35.5 million in FY 1991, an increase of 5.9 percent from the previous year. Non-ACTION support was 51 percent of the total funding for RSVP.

Characteristics of RSVP Volunteers—Distribution

By sex:	Percent
Female.....	76
Male.....	24

By ethnic group:	
White	84
Black	10
Hispanic	4
Asian/Pacific Islands	1
American Indian or Alaskan Native	1
By age:	
60 to 69	33
70 to 79	47
80 and over	20

FOSTER GRANDPARENT PROGRAM IN FY 1991

The Foster Grandparent Program (FGP) is one of the most successful and respected volunteer efforts in the United States. Through FGP, low-income persons aged 60 and older provide person-to-person service to children with special or exceptional needs. The program's budget for FY 1991 was \$62.9 million.

In FY 1991, there were 262 ACTION-funded FGP projects in all 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands. In addition, there were 13 projects totally supported by State funds.

Over 23,300 volunteers contributed about 21 million hours assisting children with special or exceptional needs, such as those who are mentally retarded, autistic, and physically handicapped. Children with special needs also include those who have been abused and neglected, runaway youth, juvenile delinquents, as well as those in need of protective intervention.

Foster Grandparents assist approximately 77,000 children every day. They serve 4 hours a day, 5 days a week. The program provides certain direct benefits to these low-income volunteers, including a stipend of \$2.35 per hour in FY 1991, transportation and meal assistance when needed, insurance protection, and an annual physical examination. Foster Grandparent services are provided through designated volunteer stations in public agencies and private nonprofit organizations. They include schools, hospitals, juvenile detention centers, Head Start programs, shelters for neglected children, State schools for the mentally retarded, and drug abuse rehabilitation.

In FY 1991, \$154,503 was allocated to nine existing projects to develop "Programs of National Significance." The objective of this new initiative is to expand program services in areas such as drug/alcohol abuse, teen pregnancy, boarder babies, and child care programs.

PROJECT EXAMPLES

Boston, MA.—Three Foster Grandparent Program (FGP) volunteers assigned to Action for Boston Community Development, work in the pediatric unit at Boston City Hospital. They serve young children with a wide variety of problems, including those who are HIV-positive. The Foster Grandparent do the "usual grandparent things"—nurturing and comforting the children. In some instances they work with some of the mothers, who themselves are very young, when they come to visit their children.

Some 65 other FGP volunteers in Boston are assigned to day care centers throughout the city. Reflecting the ethnic diversity of the city and its neighborhoods, the volunteers bring a rich body of experience to their work. Some of the volunteers are bilingual and thus are able to expand learning situations for some of the children whose first language is Chinese, Haitian, Creole, or Spanish, but not English.

Grand Forks, ND.—Under the impetus of a Programs of National Significance (PNS) grant, the Red River Valley FGP project in Grand Forks, ND has expanded its Foster Grandparent placements. Now eight Foster Grandparent volunteers serve with the only home-based Head Start program in the State. The program covers a five-county, rural area.

Foster Grandparents accompany Head Start's home visits to the homes of the families each visitor serves. While the home visitor meets with the parent, the Foster Grandparent focuses on the Head Start child by working to develop learning readiness skills.

Every other week the families, children, visitors, and Foster Grandparents gather for cluster meetings. As the above suggests, the Foster Grandparents have become an integral part of the program. Additionally, they have become a part of the community.

As a result of the PNS award, the community recognized the value of the contribution of older volunteers. When Head Start closed for the summer, new day care and tutoring opportunities were made available for the FGP volunteers.

Memphis, TN.—During the past school year, 10 Foster Grandparents in Memphis, TN worked with 31 pregnant seventh and eighth grade girls enrolled in an "optional" school for pregnant teens.

Many of the girls came from dysfunctional families and had no caring adult in their lives. Some did not know where they would be living from week-to-week. What they did come to count on, however, was their Foster Grandparents.

Over the year, the Foster Grandparents offered a wide range of life-mentoring skills to the young mothers-to-be. They also tried to prepare the girls for premature parenthood. When the babies were born, the Foster Grandparents visited in the hospital and then later in the home where they tried to monitor parenting skills.

A major goal of programs such as this is to discourage teen mothers from dropping out of school. This fall, all 31 of the girls the Foster Grandparents had worked with were back in school.

The Foster Grandparents are back, too, but this time they are working with a new group of 25 different girls.

NON-ACTION FUNDING

Some \$28.2 million in non-ACTION funding was contributed to support FGP projects nationwide. A major portion of these funds come from State governments, either through direct appropriations or contributions from State-funded agencies. The balance comes from county/city governments and private sector sources. Total non-ACTION project funds matched approximately 45 percent of the Federal appropriation for FGP in 1991.

Thirteen non-ACTION funded FGP projects are operating in the nation today: seven in Michigan, one in Wisconsin, three in New Mexico, and two in Georgia.

Characteristics of FGP Volunteers—Distribution

<i>By sex:</i>		<i>Percent</i>
Female		89
Male		11
<i>By ethnic group:</i>		
White		52
Black		36
Hispanic		8
Asian		2
Native American		2
<i>By age:</i>		
60 to 69		37
70 to 79		49
80 to 84		11
85 and over		3
Foster Grandparents with Disabilities.....		10
Characteristics of children served by foster grandparents and volunteer stations— <i>Age of children:</i>		
0 to 5		36
6 to 14		37
15 to 20		21
21 plus.....		6

SENIOR COMPANION PROGRAM IN FY 1991

The Senior Companion Program (SCP) offers person-to-person volunteer opportunities for low-income Americans 60 years of age and older. The Companions provide personal assistance and peer support, primarily to older adults. Clients served by Companions are chronically homebound with physical and mental health limitations and at risk of institutionalization. Senior Companions strengthen their clients' capacity to live independently in the community. They also ease the transition from institutions back into the community.

The program's appropriation for FY 1991 was \$27.6 million, funding 143 projects. In addition, there were 37 projects totally supported by non-ACTION funds. Over 11,700 volunteers served nearly 29,900 clients, primarily older adults, in FY 1991.

Fourteen projects received "Programs of National Significance" awards totalling \$183,800. These awards are supporting over 58,000 additional hours of Senior Companion service intended to (1) assist individuals with chronic and debilitating illness-

es, (2) decrease drug and alcohol abuse, (3) provide respite care for caregivers of frail elderly and individuals, and (4) provide care to developmentally disabled adults.

A total of \$382,349 in administrative costs increases was awarded to the 143 SCP projects to provide some relief to projects adversely impacted by inflation. Funds were used for administrative and volunteer expenses.

PROJECT EXAMPLES

Detroit, MI.—A 75-year-old visually impaired male Senior Companion has been successfully matched for over a year with an 81-year-old client who has Alzheimer's disease and is legally blind.

Prior to the match, the client would not get out of bed, was withdrawn and non-conversant. His family caregiver was overwhelmed and overburdened by caring for the client. Due to the Companion's commitment and perseverance in developing a personal relationship, and exercise regime, the client is able to take short walks and is increasingly responsive to his environment. A common bond between the Senior Companion and his client that grew from their service in World War II contributed to the client's desire to improve his mobility.

The caregiver, the volunteer and the client have developed a strong working relationship. The respite provided by the Companion three days per week has enabled the caregiver to visit with friends, shop, and catch up on her sleep.

The Companion is one of the visually impaired volunteers placed with the Greater Detroit Services for the Blind Agency. Senior Companion projects in Detroit, MI; Pittsburgh, PA; El Paso, TX; and Salt Lake City, Utah, are part of a 2-year ACTION demonstration program with the American Foundation for the Blind.

Phoenix, AZ.—Although the health of a 45-year-old AIDS victim was spiraling downward, the dying man found Maria Nolasco, his Senior Companion, to be good medicine. The loving companionship gave dignity to an otherwise agonizing, lonely, fearful personal tragedy.

Ms. Nolasco, 75, visits her client 4 days a week and assists him with shopping and light housekeeping activities, but mostly she is "just there."

As a nurse's aid in hospitals most of her adult life, Ms. Nolasco finds her volunteer work energizing: "When I walk into the room of someone so sick and see him smile, it makes me feel strong and good." Prior to her assignment, the Companion received 2 weeks of pre-service orientation through the Arizona AIDS Project, the agency which coordinates placements and daily volunteer supervision.

Through a special Programs of National Significance grant awarded by ACTION, the Phoenix SCP plans to increase the number of volunteers serving AIDS victims.

Louisville, KY.—A retired female hospital worker who serves as a Senior Companion in Louisville, KY, has helped a 70-year-old diabetes and stroke victim walk again.

The paralysis left the Companion's client unable to leave her home and manage basic homemaking tasks. When the Client's physical therapy visits ended, she and her Companion continued range of motion exercises together. There were times when the Companion's tenacity was the only reason the rigorous therapy continued. Now, with the help of the Companion and a special cane, the woman can walk down her front steps and short distances from her home. She can feed herself and clean up afterward. Just as important, the two women have become good friends.

The Companion/client match was arranged through the Louisville Visiting Nurses Association, a participant in the Visiting Nurse Associations of America (VNAA)/ACTION Partnership demonstration grant.

ACTION/VNAA PUBLIC PRIVATE PARTNERSHIP PROGRAM

FY 1991 marked the completion of the first year of a 3-year partnership grant between ACTION and the Visiting Nurse Associations of America (VNAA).

Under the grant, local visiting nurse associations have joined with 18 SCP projects nationwide to increase home health care to frail elderly persons. The support services provided by Senior Companions free visiting nurses to extend professional services to a greater number of their clients. Approximately 100 volunteers are serving homebound older persons with chronic physical and mental health limitations.

The VNAA has been directed to seek foundation or private corporate funds to expand the demonstration. The grant calls for collaboration with local visiting nurse associations to:

- (1) Assure Senior Companions receive appropriate preservice and on-going training and support; and

(2) Evaluate individual projects to improve the quality of project management and to identify successful, model approaches for replication.

The VNAA is the national association representing nonprofit home health agencies that offer a wide range of home health care services in urban and rural areas. The ACTION/VNAA partnership is designed to increase and improve volunteer service through application of the SCP program model. Through the interagency agreement, the VNAA is obligated to assist the projects to identify potential funding sources and make a best effort to assure continuance of the program after Federal funds are terminated.

ACTION/AOA JOINT INITIATIVE FOR VULNERABLE ELDERLY

A 3-year demonstration program between ACTION and the Administration on Aging is nearing the end of its first phase, providing volunteer service opportunities to Senior Companions in 17 projects located in 11 states.

The volunteer placements are coordinated through State Agencies on Aging and are designed to enable Senior Companions to assist vulnerable homebound older persons. The focus is on clients aged 80 and older who are at risk of institutionalization. By providing volunteer in-home services such as grocery shopping, meal preparation, and monitoring of service delivery, SCP volunteers become client advocates who stimulate the community's natural support system needed to keep people independent of more costly public services. Approximately 90 percent of the volunteers are serving through existing Senior Companion projects.

The scope of the agreement between the two agencies is to increase collaboration at all levels to expand: (1) meaningful volunteer service opportunities for older people, and (2) volunteer services for the homebound elderly. An extensive evaluation supported by ACTION to measure the impact of the program is underway. The administration on Aging is responsible for developing community support to extend services after the demonstration period.

NON-ACTION FUNDING

Approximately \$16.7 million in non-ACTION funding was contributed to support SCP projects. Most funds come from State governments, either through direct appropriations or contributions from State-funded agencies. County/city governmental and private community sources make up the balance. Thirty-seven non-ACTION projects are operating, nationwide. New Mexico, Michigan, and Illinois have the greatest number of non-ACTION funded projects.

Characteristics of SCP Volunteers—Distribution

By sex:		Percent
Female		85
Male		15
By ethnic group:		
White/Other		54
Black		32
Hispanic		9
Asian		3
Native American		2
By age:		
60 to 69		44
70 to 79		46
80 to 84		8
85 and over		2
Client ages:		
75 plus		55
60 to 74		34
46 to 59		5
22 to 45		6

ITEM 15. COMMISSION ON CIVIL RIGHTS

DECEMBER 19, 1991.

DEAR SENATOR PRYOR: This is in response to your letter to Arthur A. Fletcher, Chairman of the U.S. Commission on Civil Rights, requesting information for your annual report, *Developments in Aging*.

During fiscal year 1991, the Commission continued to process complaints; of 2,850 complaints received as of December 13, 1991, 132 alleged discrimination on the basis

of age and were referred to the appropriate agency. (The Commission not authorized to investigate complaints, except for those alleging denial of voting rights.)

The U.S. Commission on Civil Rights reaffirmed its commitment to securing legal protection for individuals against arbitrary discrimination on the basis of age, when it initiated a study on age discrimination in employment in 1990. Continuing into 1991, the study reviewed the impact of legal developments on contemporary problems facing today's older employee.

Among the issues addressed by the study were:

A. Age discrimination enforcement by the Equal Employment Opportunity Commission, including: (1) conciliation, (2) investigation process, (3) referral agreements with State agencies, (4) backlogs in complaint processing, and (5) problems in investigating complaints by the end of the statute of limitations.

B. The legal and economic impact of employee waivers of rights to bring suit under early retirement plans, separation agreements with special payments, and similar agreements.

C. Legal considerations for pension and employment benefit plans, the *Betts* decision, and the Older Workers Protection Act of 1990.

D. A review of current employer programs which address the needs of older persons.

E. An analysis of myths and stereotypes and their role in the institutional employment process.

The study was curtailed by legislative developments and an investigation of the EEOC by the General Accounting Office. Additionally, fiscal and human resource constraints forced the Commission to limit its study.

On October 29, 1990, the Commission's New York Advisory Committee held a forum in Buffalo, NY, on housing issues. One of the areas covered was nursing home availability for minority elderly persons. Several people addressed the topic, and a report is being prepared.

If you have any questions regarding this information, please feel free to contact my Executive Assistant, Ms. Romey Lucero, at 202/523-5571.

Sincerely,

WILFREDO J. GONZALEZ,
Staff Director.

ITEM 16. CONSUMER PRODUCT SAFETY COMMISSION

OCTOBER 18, 1991.

DEAR MR. CHAIRMAN: Enclosed, as you requested, is a report by the U.S. Consumer Product Safety Commission on activities to improve safety for older consumers.

I appreciate the opportunity to submit this information to your Committee.

Best wishes.

Sincerely,

JACQUELINE JONES-SMITH.

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 million people over age 65 are treated in hospital emergency rooms for injuries associated with products they live with and use everyday. The death rate for older people is approximately three times that of the younger population for unintentional injuries in the home. Specifically, there are 60 deaths per 100,000 persons 65 and older, while there are 20 deaths per 100,000 persons under 65.

Slips and falls are the main source of injury for older people in the home. Older consumers can slip in the bathroom, especially in the bathtub. Falls can happen on stairs, stepstools, and floors with loose carpets. When older people fall, their risk of serious injury or death is much higher than that of the general population. CPSC recommends the use of grab-bars and nonslip mats by the bathtub; handrails on both sides of the stairs; and slip-resistant carpets and rugs.

Burns occur from hot tap water and from open flame. CPSC recommends the installation and maintenance of smoke detectors on every floor of the home. Older consumers should look for nightwear that would resist flames, such as a heavy weight fabric, tightly woven fabrics such as polyester, modacrylics, or wool. CPSC also recommends that consumers turn down the temperature of their water heater to 120 degrees Fahrenheit to help prevent scalds.

In 1991, CPSC distributed publications to promote safety for older consumers. These publications include:

"Home Safety Checklist for Older Consumers," a room-by-room check of the home, identifying hazards and recommending ways to avoid injury. In the past year, CPSC distributed 52,000 copies of this checklist. Since the checklist was originally produced in 1985, more than 1.5 million copies have been distributed nationwide. Consumers may request a copy by sending a postcard to "Checklist for Older Consumers," CPSC, Washington, D.C. 20207.

"What Smart Shoppers Know About Nightwear Safety," a brochure developed by a group of experts in apparel flammability and distributed jointly by CPSC and the American Association of Retired Persons (AARP). The brochure encourages older consumers to look for sleepwear that is flame resistant. Consumers may request a copy by sending a postcard to AARP, 601 E Street, NW, Washington, D.C. 20049.

The Commission has proposed changing the test protocol for child-resistant closures to make it easier for older people to use safety closures. CPSC has data estimating that the widespread use of child-resistant closures on oral prescription medicines saved the lives of more than 400 children under age 5 since 1974. However, many adults (including older consumers) do not use child-resistant packaging because they find it physically difficult to use.

In October 1990, CPSC proposed amendments to its regulations under the Poison Prevention Packaging Act to make packaging easier to open by adults, but still retain child resistance. CPSC proposed to change the regulation by requiring that the 100 adults on the test panel be 60 to 75 years of age and that these adults be able to open the package within 1 minute. This is expected to increase the use of child-resistant closures by all adults.

Two public hearings (in December 1990 and September 1991) were held to gather public comments about the proposed changes. If made final, this change will encourage industry to develop innovative closures that appeal to older people's "cognitive skills" instead of their physical strength. In addition, CPSC reminds all adults to keep medicines out of the reach of children who can be poisoned if they swallow medicines or household chemicals.

ITEM 17. ENVIRONMENTAL PROTECTION AGENCY

DECEMBER 11, 1991.

DEAR MR. CHAIRMAN: In response to your request of October 2, 1991, to Administrator Reilly regarding information on the activities of older workers at the Environmental Protection Agency to be included in your annual report, *Developments in Aging*, I have enclosed a summary report of the Agency's 1991 activities.

Sincerely yours,

ERICH W. BRETTHAUER,
Assistant Administrator for Research and Development.

Enclosure.

ENVIRONMENTAL PROTECTION AGENCY

A. In 1976, the U.S. Environmental Protection Agency (EPA) and the Administration on Aging established the Senior Environmental Employment (SEE) Program. The program has two purposes. It demonstrates the effectiveness of older Americans in helping to prevent, abate, and control environmental pollution. It also provides meaningful employment to retired/unemployed older Americans who have a wealth of talent, experience, and skills.

For 16 years, EPA has used the SEE program to marshal the expertise of older Americans in support of the Agency's Legislative Goals. Older workers are stationed in all of EPA's 10 regional offices, 20 laboratories, field sites and several State offices. Retired noise experts have provided technical assistance to local communities in conducting noise surveys and serving as noise abatement teachers in classes for local businessmen. On the subject of indoor radiation, SEE experts helped to gather and analyze samples, maintain equipment, and answer questions for local citizens. In the area of solid waste management, SEE enrollees provided the experienced "extra hands and minds" to help local communities establish proper disposal procedures. Through the Asbestos in Schools program, a group of very knowledgeable SEE enrollees were temporarily hired and trained to work with local school districts to assess the problem and recommend the technically correct remedial action.

During the past year, the Federal Communications Commission (FCC) has established their own Senior Environmental Employment Program using EPA's program as a model. Additional programs are being developed with the technical assistance and support of EPA's SEE staff, again using EPA's very successful SEE Program as

the model, for the Occupational Safety and Health Commission (OSHA), Federal Departments of Interior, Agriculture, Defense, Veterans Affairs, and in the States.

No matter what the critical environmental issue—from understanding and explaining the analyzed data of nearby toxic exposures to local citizens and elected officials or providing a large staff to spot check underground storage tanks and nozzle violations—the SEE program marshalls the temporary technical talent when and where it is more needed. In the true sense, the Federal Government has begun to draw upon a vast and previously untapped resource.

B. Also, during the past year, the Laboratory Director and staff at the EPA Environmental Research Laboratory in Athens, GA, have completed plans to establish an Elder Day Care Center for its employees. The facility will be opened by June 1992.

While everywhere in this country, people and public policy is focusing on the importance of providing childcare services for employees with young children, the staff at the Athens laboratory expanded their attention to include eldercare services. Under the current plan, EPA's laboratory will provide both childcare and eldercare services for its employees. The childcare facility will house about 65 youngsters and the eldercare facility will accept about 12 adults.

Over the last 4 years, on-site child care has become common in Federal buildings and is viewed as an important step toward relieving the burden on working parents. But there exists little in the way of services for the elderly.

The EPA program in Athens could be a model for other agencies looking for ways to meet workers' needs and enhance their own competitiveness as employers. The key to the plan in Athens is to combine facilities and services for two population categories. The concept used in private enterprise daycare facilities blends together seniors and pre-schoolers for mutually beneficial results. In these combined facilities the adults help in caring, training and mentoring the daycare children while being integrated into a social setting which insures their own care and limits their own solitary existence.

The IRS, after hearing about the EPA plan for the combined daycare facility, is examining the needs of its own employees for eldercare services in many of its existing buildings where it has supported the construction of childcare centers.

EPA to Offer Elder Day Care at Georgia Research Lab

By Rita L. Zeidner

Daycare services for the elderly will be provided to employees at the Environmental Protection Agency's Environmental Research Laboratory in Athens, Ga.

"It's important to provide childcare services for employees with young children. But many of us will be faced with elder care needs for our parents," said Rose Marie Russo, director of the 300-person laboratory.

Under a plan still being refined, the EPA laboratory will provide both childcare and "eldercare" services, according to Wayne Garrison, an EPA chemist. Garrison is the father of three small children and one of a small group of workers who volunteered to help design the center.

The childcare facility will house about 65 youngsters, infants through school age. The eldercare services will

take in about 12 adults who are 55 or older.

Demographic data indicate that as the U.S. population grows older, an increasing number of workers will have to deal with health concerns of their parents and other older relatives.

Over the last four years, on-site child care has become common in federal buildings and is viewed as an important step toward relieving the burden on working parents. But there exists little in the way of services for the elderly.

A 1990 survey by the Office of Personnel Management showed nearly 80 percent of all federal agencies had some kind of dependent care program in place. About half of all agencies provide childcare information and about a third of the government's facilities have a childcare center on-site.

But fewer than a third of agencies provide information or referral services geared toward elder care.

The EPA program in Athens could be a model for other agencies looking for ways to meet workers' needs and enhance their own competitiveness as employers.

While minimum requirements for child daycare programs are set by the state, Garrison said many features of the childcare and eldercare programs will be determined by employees.

Employees have voiced a need for infant, toddler and pre-school care, as well as a latch-key program to provide supervision and activities for children after school.

Ideally, Garrison said, the adult care program will include activities, as well as some level of medical care such as physical therapy.

Construction, originally planned to begin this fall, has been delayed until winter, but the center should be open by June 1992, Garrison said.

Rates have not yet been determined,

but costs will be set on a par with local childcare centers and the few senior centers in the area, he said.

EPA employees at the laboratory will have first priority at placing their family members in the center. If they do not fill all the slots, other federal workers in the area will have a chance to enroll family members.

The IRS, which supported the construction of childcare centers in many of its buildings, also is examining the need for eldercare services, according to Bill Coleman of the agency's work and family program, a division established specifically to look at issues such as dependent care.

"We're looking at it in terms of employee recruitment and retention and having this as an added benefit," Coleman said. "As the work force changes, employee needs will change," he said.

"We'd like to be poised to accommodate these changes."

ITEM 18. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

OCTOBER 29, 1991.

DEAR CHAIRMAN PRYOR: On behalf of Chairman Kemp, I am responding to your October 2, 1991 request for the Equal Employment Opportunity Commission's submission for the Committee's annual report, *Developments in Aging*.

Enclosed are copies of fiscal year 1990 annual reports from EEOC's Office of General Counsel¹ and Office of Program Operations. These reports contain information on EEOC's compliance and litigation enforcement efforts on behalf of victims of employment discrimination.

Please call me at 663-4900 if I can be of further assistance.

Sincerely,

RONNIE BLUMENTHAL,

Acting Director of Communications and Legislative Affairs.

Enclosures.

¹ Report of the General Counsel held in Committee files.

OFFICE OF PROGRAM OPERATIONS



ANNUAL REPORT
FISCAL YEAR 1990

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
MISSION STATEMENT

To ensure equality of opportunity by vigorously enforcing federal legislation prohibiting discrimination in employment through investigation, conciliation, litigation, coordination, regulation in the federal sector, and through education, policy research and provision of technical assistance.

INTRODUCTION

The Office of Program Operations was created in 1982 to manage administrative enforcement activities mandated by federal statutes and the EEOC mission statement. The Director of OPO serves as a principal advisor to the Chairman on equal employment opportunity, administrative enforcement and federal affirmative employment matters. OPO staff ensures the effective and efficient management of the Commission's administrative enforcement and federal affirmative employment programs. The immediate Office of the Program Director has overall supervisory, managerial and fiscal responsibility for the six program areas described in this report and for the fifty field offices which carry out the program activities associated with EEOC's law enforcement mandate.

This report provides information regarding the status and accomplishments of OPO in FY 1990. The report is divided into six sections, as follows:

Section 1. Introduction

Section 2. FY 1990 Highlights

Section 3. Overview of the OPO Organization

Section 4. Program Area Accomplishments

Section 5. Leadership - Special Activities

Section 6. Data Table Appendix

The FY 1990 Highlights section presents graphics and information on the major accomplishments for the fiscal year. Following that, the Overview provides information on the OPO organizational structure, mission and functions of OPO headquarters and district offices and the OPO goals and objectives for FY 1990. The Program Area Accomplishments section provides detail on the year's achievements by program area. This section also adds to the descriptions of primary program areas provided in the Overview. The Leadership - Special Activities Section describes some of the important events and leadership activities during the year. Section 6, the Data Table Appendix, provides supporting detail on the agency's charge and complaint processing performance trends.

HIGHLIGHTS

Selected Performance Indicators

OFFICE OF PROGRAM OPERATIONS

FISCAL YEAR 1990 HIGHLIGHTS

During FY 1990, the Office of Program Operations once again accomplished its major program goals and objectives. For the past three years, OPO headquarters and field office efforts have been concentrated on achieving consistent objectives to attain maximum efficiency of operations while continuing to improve the quality of charge resolution work.

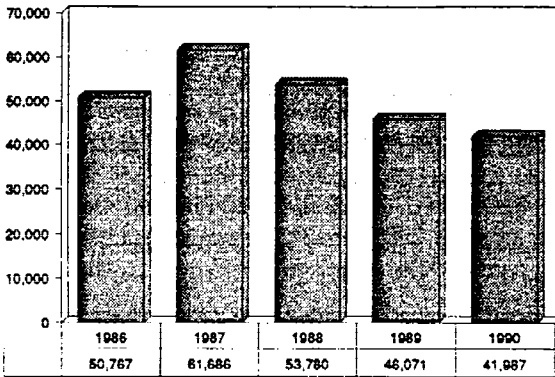
The final results, as measured by agency-wide charge processing performance indicators, speak for themselves. These results reflect major reduction of the pending work load of charges and complaints, maintenance of high staff productivity in charge and complaint resolutions, enhancement of the systemic charge process, reduction in the rework of charges as directed by management review, continued decrease in average charge processing time, reduction in the age of the open inventory and an increase in litigation activity.

OPO's integrated approach to case development and case management continued to have a positive effect on investigative outcomes and work load management in FY 1990. With more intensive utilization of automated systems for tracking and monitoring the work load, with a continuing focus on the conduct of thorough investigations - preferably on-site - with increased managerial attention to the planning and development of quality investigations, with renewed emphasis on full employee participation in the process and with meaningful improvements in the work environment, this year's objectives were achieved. All of these initiatives contributed to the progress made this

year. The commitment of OPO field and headquarters staff to the implementation of innovative methods and to the application of agency-wide leadership principles was particularly critical to this year's progress in, once again, accomplishing more with less.

On the following pages in this section are charts depicting highlights of FY 1990 progress related to trends over time. Brief narratives and data tables accompany the charts in selected areas of field performance.

ENFORCEMENT PENDING INVENTORY

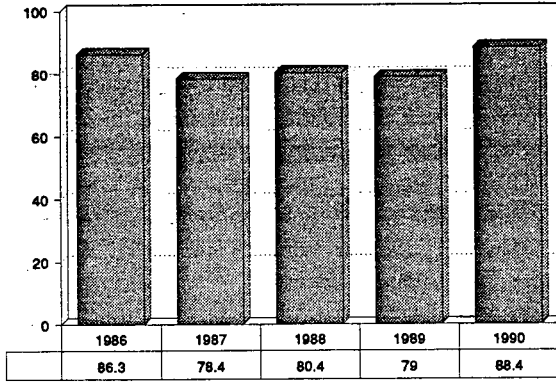


The number of charges/complaints pending in the agency's inventory was reduced by 8.9 percent in FY 1990. This was 5.4 percent less than the amount of reduction achieved last year;

however, it should be recognized that this year's reduction was achieved with 9.1 percent fewer investigators available and with a 6.2 percent increase in receipts to process.

<u>Fiscal Year</u>	<u>Pending Inventory</u>	<u>Receipts to Process</u>	<u>Investigators Available</u>
1989	46,071	55,952	838.1
1990	41,987	59,426	762.2
Difference	- 4,084	+ 3,474	- 75.9

ENFORCEMENT PRODUCTIVITY Resolutions per Staff Investigator

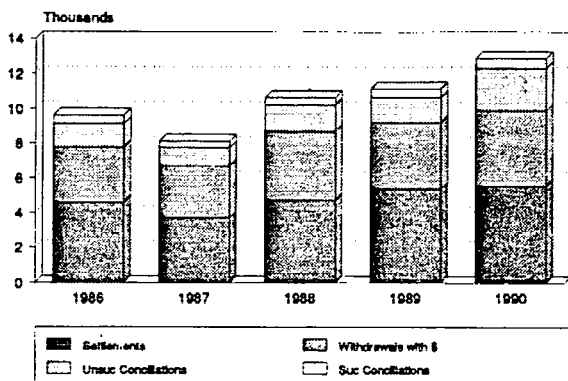


Individual productivity rose sharply in FY 1990 from 79.0 resolutions per available investigator to 88.4. As a result, the agency was able to reduce its pending inventory in spite of a 6.2 percent increase in receipts to process and a 9.1 percent decrease in

investigators available. The total resolutions (67,415) represent an increase over FY 1989 of 1,206 resolutions (1.8 percent). This is a ratio of 1.13; that is, for every charge received to process, 1.13 were resolved.

<u>Productivity/ Staffing</u>	<u>FY 1986</u>	<u>FY 1987</u>	<u>FY 1988</u>	<u>FY 1989</u>	<u>FY 1990</u>
Productivity	86.3	78.4	80.4	79.0	88.4
Staff Avail.	720.4	682.2	880.0	838.1	762.2

MERIT RESOLUTIONS



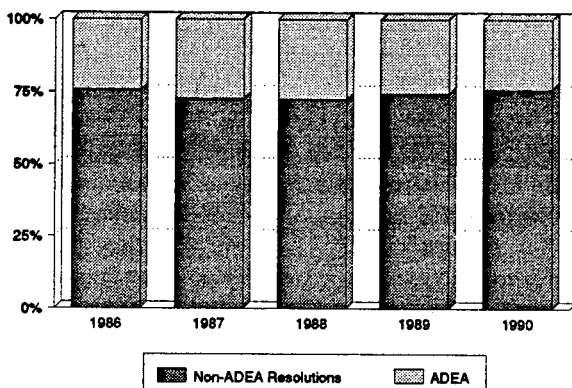
Merit resolutions are those outcomes that are favorable to the charging party. They consist of settlements, withdrawals with benefits and successful and unsuccessful conciliations. These resolutions continued to increase in FY 1990 reaching a high of 12,880. This total represented an

increase in the merit factor from 16.8 percent of total resolutions in FY 1989 to 19.1 percent. The table below shows that the percentages of merit resolutions by statute are roughly equivalent to the percentages for receipts to process by statute.

MERIT RESOLUTIONS/RECEIPTS TO PROCESS - BY STATUTE

	<u>TITLE VII</u>	<u>ADEA AND ADEA/VII</u>	<u>EPA AND EPA/VII</u>	<u>OTHER</u>
Merit Resolutions	74.6%	22.4%	2.9%	0.1%
Receipts to Process	73.3%	24.4%	2.1%	0.2%

ADEA to NON-ADEA RESOLUTIONS



For the third year in a row, resolutions of charges filed under the Age Discrimination in Employment Act (ADEA) exceeded ADEA receipts to process (RTP). These ADEA RTP and resolution totals include charges filed under ADEA and those filed concurrently

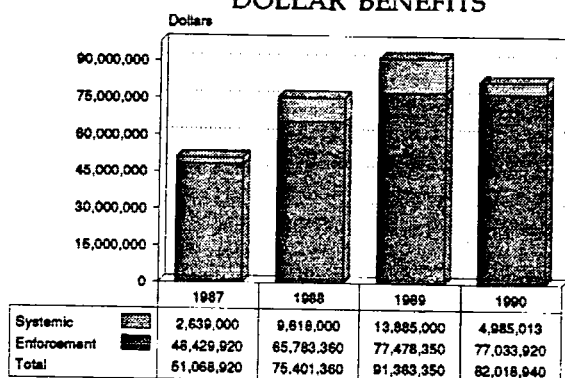
under ADEA and Title VII. The ratio of ADEA RTP to resolutions in FY 1990 was 1.12. There were 14,526 ADEA RTP and 16,269 resolutions. ADEA/ADEA-Title VII charges were 24.1 percent of total charges compared to 25.7 percent in FY 1989.

ADEA AND OTHER STATUTES (Resolutions to Receipts to Process Ratio)

	<u>FY 1986</u>	<u>FY 1987</u>	<u>FY 1988</u>	<u>FY 1989</u>	<u>FY 1990</u>
ADEA/ADEA-					
TITLE VII					
-Rec.to Proc.	17,443*	15,121	14,882	14,789	14,526
-Resolutions	14,933	14,530	19,427	16,989	16,269
-Ratio	.86	.96	1.31	1.15	1.12
OTHER					
-Rec.to Proc.	51,379*	46,953	43,971	41,163	44,900
-Resolutions	48,513	38,952	51,322	49,220	51,146
-Ratio	.94	.83	1.17	1.20	1.14

* In FY 1986 only, receipts by statute are based on total receipts.

TOTAL DOLLAR BENEFITS



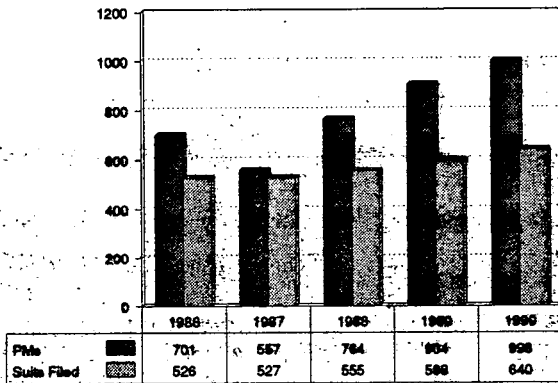
Monetary benefits obtained as a result of enforcement unit activities remained level with FY 1989 at \$77.0 million. As illustrated in the table below, these monetary benefits went to 9,861 people in FY 1990, 19.1 percent fewer people

than were benefited the year before. However, the people benefited in FY 1990 received 22.9 percent more in dollar benefits on average than FY 1989 benefit recipients.

PEOPLE BENEFITED/AVERAGE DOLLAR BENEFIT PER PERSON (Enforcement Only)

	<u>FY 1986</u>	<u>FY 1987</u>	<u>FY 1988</u>	<u>FY 1989</u>	<u>FY 1990</u>
No. Benefited	12,889	5,500	8,667	12,187	9,861
Average Benefit	4,177	8,805	7,588	6,357	7,812

PRESENTATION MEMORANDA AND TOTAL SUITS FILED

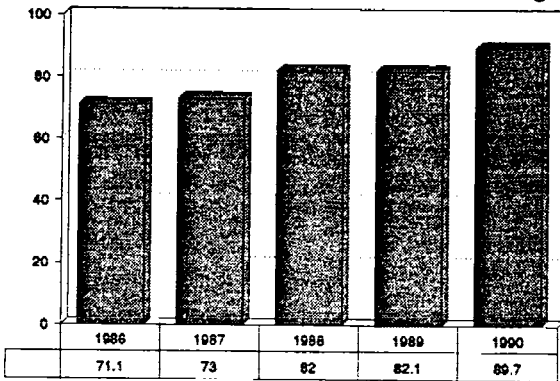


Presentation Memoranda (PMs) submitted by the field offices to the Office of General Counsel for Commission approval continued to increase in FY 1990 reaching a total of 998. (This total agrees with OGC's preliminary report.) This was a 10.4 percent increase in recommendations. The number of lawsuits filed also increased

in FY 1990. As shown in the data table below, there was a 6.8 percent increase in suits filed this year. Over time, since FY 1986, PMs submitted by the field offices have increased by 42.4 percent and lawsuits have increased during the same time period by 21.7 percent.

<u>PRESENTATION MEMORANDA/LAWSUITS (Percentage Increases)</u>				
	<u>FY 1987</u>	<u>FY 1988</u>	<u>FY 1989</u>	<u>FY 1990</u>
PMs	- 20.5%	+ 37.2%	+ 18.3%	+ 10.4%
Lawsuits Filed	+ 0.2%	+ 5.3%	+ 7.7%	+ 7.0%

HEARINGS PRODUCTIVITY Resolutions per Administrative Judge



Average productivity per Administrative Judge continued to increase in FY 1990 reaching a five-year high of 89.7 resolutions per AJ. Because of this high productivity, an increase in the pending inventory was held to 12.1 percent in spite of a 4.5 percent increase in the number of complaints

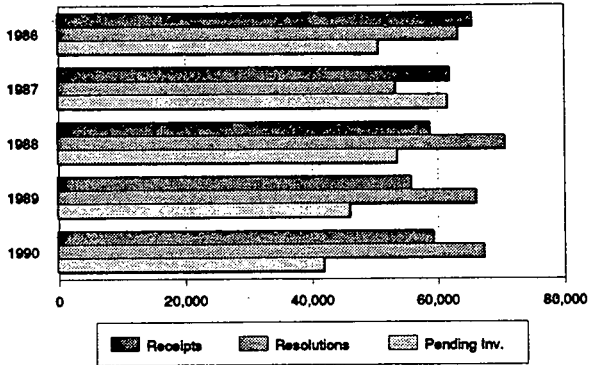
received and a continuing decrease in the number of AJs available. Since FY 1986, the number of AJs available has decreased from 73 to 58. However, because high productivity was maintained during this time period, the inventory was reduced for three consecutive fiscal years, from FY 1987 through FY 1989.

HEARINGS - WORK LOAD AND STAFFING

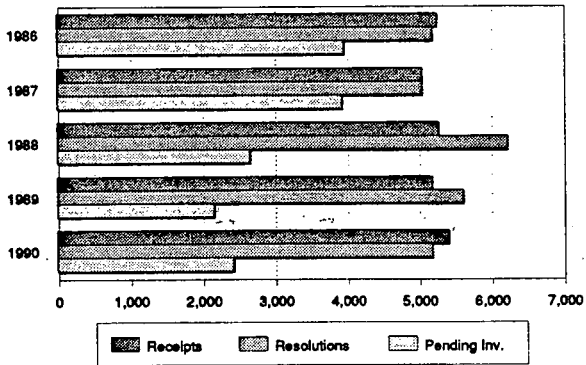
	<u>FY 1986</u>	<u>FY 1987</u>	<u>FY 1988</u>	<u>FY 1989</u>	<u>FY 1990</u>
Receipts	5,258	5,045	5,278	5,183	5,417
Available AJs	73	69	76	68	58
Pending Inv.	3,959	3,929	2,651	2,159	2,421

Additional Charts
Supporting Graphics and Data

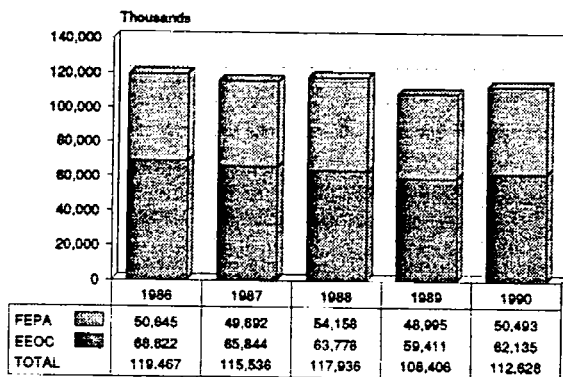
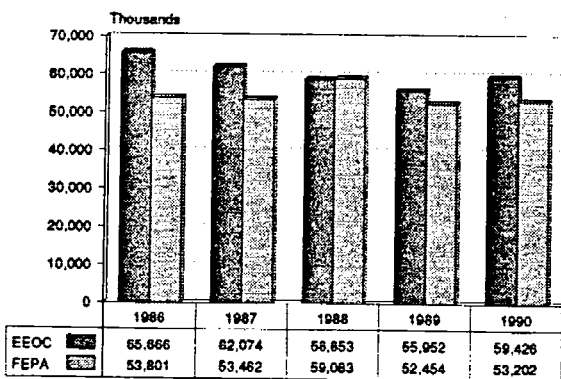
ENFORCEMENT WORKLOAD



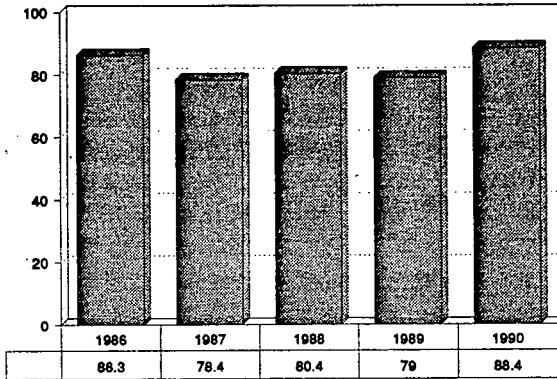
HEARINGS WORKLOAD



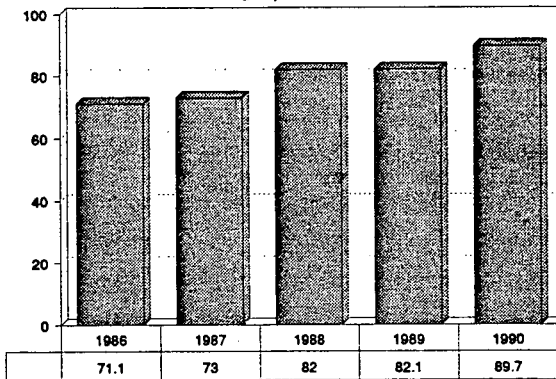
TOTAL RECEIPTS

RECEIPTS TO PROCESS
BY AGENCY

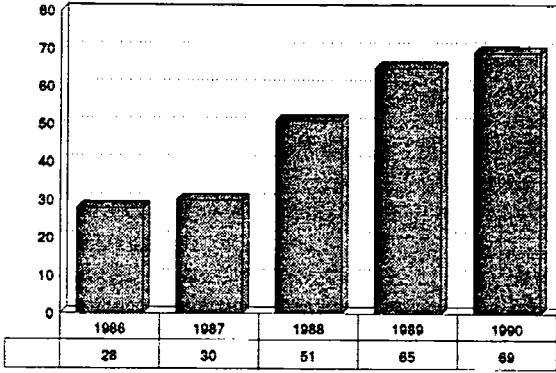
ENFORCEMENT PRODUCTIVITY Resolutions per Staff Investigator



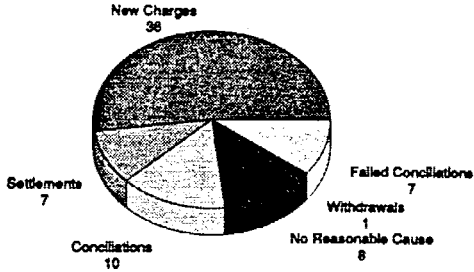
HEARINGS PRODUCTIVITY Resolutions per Administrative Judge



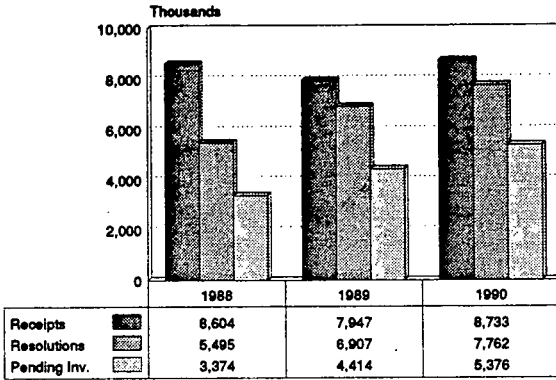
**SYSTEMIC CASE ACTIONS
Approvals by Commission Vote**



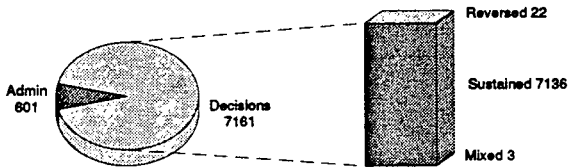
**FY 1990 SYSTEMIC CASE ACTIONS
BY TYPE**



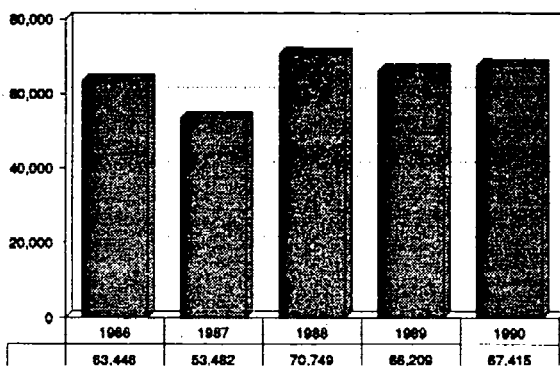
DETERMINATIONS REVIEW PROGRAM



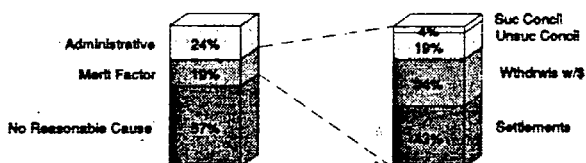
DRP REVIEWS



ENFORCEMENT RESOLUTIONS



RESOLUTIONS BY TYPE 1990



OVERVIEW

OFFICE OF PROGRAM OPERATIONS - OVERVIEW

FY 1990 MISSION AREAS

The three FY 1989 OPO Mission Areas were carried forward to FY 1990, to continue to build on the solid foundation of integrated systems which have been established over time. The Mission Areas are:

- (1) Ensure quality and timeliness of agency wide charge/complaint processing (enforcement, systemic, hearings, and litigation development)
- (2) Ensure efficient and effective equal employment opportunity programs in the federal sector
- (3) Ensure effective accomplishment of operational responsibilities

The Office of Program Operations set major program goals and objectives under these three FY 1990 Mission Areas. Accomplishment of the specific objectives depend, as always, on integrated, well-managed systems - agency-wide and within the individual field offices.

Specific strategies upon which OPO accomplishments are built include:

Implementation of uniform case management principles and systems for timely identification of problems

Resolution of problems through technical assistance for enforcement investigative activities and federal hearings procedures

Development and implementation of appropriate review to improve oversight capabilities and enhance evaluation of performance Development of data management systems, research activities, and reporting systems to provide enhanced statistical analyses in support of charge/complaint resolution activities in the private and public sectors

Development and communication of policy and procedural guidance for field office enforcement in private sector charge processing and for federal agency compliance with complaints processing systems and affirmative employment requirements

Development and implementation of innovative techniques and approaches to enhance the enforcement capabilities of the state and local FEPAs and TEROs

Implementation of activities designed to increase the general public's knowledge of rights, employers' knowledge of responsibilities and FEPA staffs' ability to perform

Improvement of field/headquarters communication and coordination.

OFFICE OF PROGRAM OPERATIONS - OVERVIEW
PROGRAM OFFICE FUNCTIONS

The Office of Program Operations includes the Office of the Director and six program area offices. The individual program offices are structured to ensure efficient operations for the accomplishment of OPO goals and objectives. The functional responsibilities for each of the component offices are described below.

Office of the Director

Provides overall direction, coordination, leadership and administrative support to the OPO program areas and has supervisory, management and fiscal responsibility for the Office of Program Operations.

Field Management Programs (FMP) East and West

Ensures effective and efficient operation of field offices through operational oversight and monitoring of program implementation, evaluation of performance, and provision and coordination of technical assistance and administrative services.

OPO's Field Management Programs is divided into East and West geographic regions for effective management of the 50 field offices. The field offices are charged with accomplishing the statutory responsibilities of the Commission through investigation, conciliation and litigation of charges filed, achieving timely and appropriate resolution of discrimination charges through the efficient administration and effective implementation

of systematic case development and case management.

Systemic Investigations and Individual Compliance Programs (SIICP)

Develops and recommends charge processing procedures, provides technical and administrative support systems for systemic and individual charge investigation and develops intermittent instructions which assist field staff in the timely investigation of Title VII, EPA and ADEA charges. SIICP investigates large systemic charges and provides case-by-case technical assistance to district offices as they accomplish pattern and practice charge investigative responsibilities.

SIICP is also responsible for the development and monitoring of EEOC's working relationship with the state and local Fair Employment Practices Agencies (FEPAs) and Tribal Employment Rights Organizations (TEROs).

Federal Sector Programs (FSP)

Provides leadership and guidance to federal agencies on all aspects of the federal government's equal employment opportunity program. FSP develops proposed policies and monitors implementation of approved affirmative employment policies and programs designed to ensure hiring, placement and advancement of minorities, women and people with disabilities in the federal government. FSP also has oversight responsibility for federal agency pre-appellate complaint processing programs,

with specific program management responsibility at the hearing stage.

Determinations Review Program (DRP)

Implements the Commission policy that provides charging parties with the opportunity to seek headquarters review of no reasonable cause determinations issued by field offices. DRP reviews these determinations upon request of charging parties in which field staff has determined that there is no reasonable cause to believe the charges have merit. DRP's full review of charge investigations is completed by both investigators and attorneys and may sustain the field determination, cause the charge to be remanded for further investigation, or may recommend reversal to the Program Director.

Operations Research and Planning Programs (ORPP)

Produces summary statistical reports of data required by OPO in planning and carrying out its functions; designs and conducts surveys of employment sectors; analyzes data from employment sectors and from OPO field and headquarters offices; produces research reports on the employment sector; conducts and issues reports on effective field office investigative strategies; and provides long and short range planning systems from which OPO decisions regarding operational plans and goals, resource and staffing determinations and workload distribution may be made on a national and office specific basis.

Program Support Services Staff (PSSS)

Provides program related services and assistance to headquarters and field

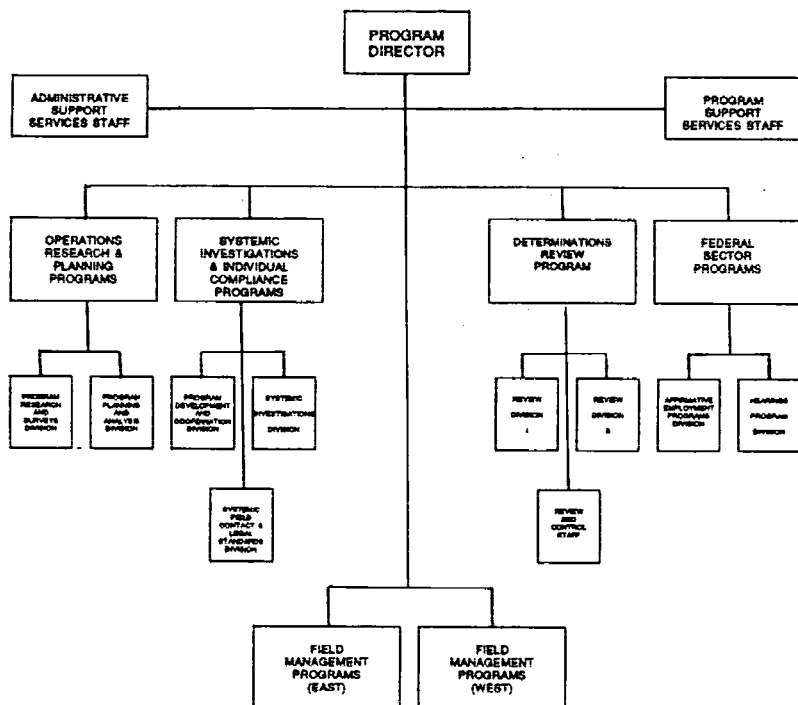
components of OPO in accomplishing its mission and goals; designs and implements staff development efforts and related improvement programs to enhance the quality of the agency's charge processing and case and resource management.

Administrative Support Services Staff (ASSS)

Provides administrative and technical support and services to all OPO components. In addition, conducts comparative analyses of financial transactions and monitors their impact on budget allocations; administers the OPO management reporting system; and, conducts special studies and evaluations on specific program office units.

Organization
Chart

OFFICE OF PROGRAM OPERATIONS
FISCAL YEAR 1990



**OFFICE OF PROGRAM OPERATIONS
FIELD MANAGEMENT PROGRAMS
FISCAL YEAR 1990**



DISTRICT, AREA AND LOCAL OFFICES					
FIELD MANAGEMENT PROGRAMS (EAST)			FIELD MANAGEMENT PROGRAMS (WEST)		
ATLANTA	CLEVELAND	NEW YORK	CHICAGO	INDIANAPOLIS	SAN ANTONIO
SAVANNAH	CINCINNATI	BOSTON		LOUISVILLE	EL PASO
		BUFFALO	DALLAS		
BALTIMORE	MEMPHIS	PHILADELPHIA	OKLAHOMA	LOS ANGELES	SAN FRANCISCO
NORFOLK	LITTLE ROCK	NEWARK	CITY	SAN DIEGO	FRESNO
RICHMOND	NASHVILLE	PITTSBURGH	DENVER	MILWAUKEE	HONOLULU
				MINNEAPOLIS	SAN JOSE
BIRMINGHAM	MAMI	ST. LOUIS	DETROIT		
JACKSON	TAMPA	KANSAS CITY		PHOENIX	SEATTLE
			HOUSTON	ALBUQUERQUE	
CHARLOTTE	NEW ORLEANS	WASHINGTON, D.C.			
GREENSBORO					
GREENVILLE					
RALEIGH					

ACCOMPLISHMENTS

OFFICE OF PROGRAM OPERATIONS

FY 1990 ACCOMPLISHMENTS

FMP ACCOMPLISHMENTS

Field Management Programs (FMP) has responsibility for oversight of all field office activities. FMP monitors performance in the 50 offices by analyzing relevant data on an on-going basis with especially careful analysis of performance indicators at the end of each quarter. This enables top managers to determine the extent to which overall goals and objectives are being met and also provides the means for identifying problem areas. This information is then used to introduce appropriate national and office specific programs to continue to improve the high level of field office performance. Throughout the year, FMP's management oversight activities resulted in greater consistency of field performance.

Charge Receipts to Process

During the year, EEOC and FEPAs received 112,628 charges/complaints filed by individuals. Of these, 59,426 (52.8 percent) were EEOC charges for processing. This is a 6.2 percent increase over last year in EEOC receipts to process reversing a downward trend in receipts to process that began in FY 1986.

Of the 59,426 charges EEOC received to process, 73.3 percent (43,532) were filed solely under Title VII, while 24.4 percent (14,526) were filed under ADEA or were filed concurrently under ADEA and Title VII. The remaining 2.3 percent (1,368) alleged violations of the Equal Pay Act (EPA) or were filed concurrently under other combinations of the three statutes enforced by the agency.

FEPA receipts to process totaled 53,202 or 47.2 percent of the 112,628 charges/complaints filed. This represents an increase over FY 1989 of 1.4 percent in FEPA receipts to process. FEPA receipts to process this year included 43,547 (81.9 percent) charges filed solely under Title VII, 9,584 (18.0 percent) filed under ADEA and ADEA/Title VII, 34 (0.1 percent) under EPA and EPA/Title VII, and the remaining 37 (0.1 percent) filed concurrently under other combinations of the three statutes.

Charge Resolutions

There is continuing emphasis on improving the quality and timeliness of charge resolution, and, despite staff reductions, field offices again made solid gains in charge resolution this year. The 50 field offices resolved 67,415 charges, 1.13 charges resolved for every one received for processing. FY 1990 productivity averaged 88.4 resolutions per available investigator, an increase of 9.4 resolutions per investigator over last year's average of 79.0.

Pending Inventory

In spite of staff reductions, the agency again made significant progress toward reducing the size of the pending inventory. The number of charges in pending inventory declined during FY 1990 to 41,987, down 4,084 charges (8.9 percent). This is a 7.9 month work load, which is down from last year's 8.1 mark. This

trend represents continuing progress toward the agency goal of 6.0 months. Significant achievements were made by several of the field offices in controlling their work loads, as show below.

<u>Pending Inventory</u> <u>No. of Offices</u>	<u>Months of Inventory:</u>
Eleven	Less than Six Months
Fifteen	Six to Eight Months
Seven	Eight to Ten Months
Ten	Ten to Twelve Months
Seven	More than Twelve Months

Aged Charges

Aged charges are those charges in open inventory which are 270 days old or older. Goals have been set each year for reducing the number of such charges in the workload with an agency objective of reducing the percentage to 15.0. During FY 1990, that objective was attained with a reduction from FY 1989 of 8.9 percent. Furthermore, 11 of the 50 field offices ended the year with less than 1.0 percent aged charges in their inventories. Other timeliness indicators also showed improvement, as average processing time was reduced by 11 days, from 295 to 284 days, and the average age of the open inventory was reduced from 310 to 233 days.

Merit Resolutions

Merit resolutions, which reflect EEOC's commitment to quality, include settlements, withdrawals with benefits, successful conciliations and unsuccessful conciliations. It is believed that improvements in the quality of investigations result in an increase in the rate of merit resolutions. During FY 1990, the merit factor continued to increase and rose by 2.3 percentage points, from 16.8 percent of total resolutions to 19.1

percent.

Determinations on the Merits

Determinations on the merits reflect three types of resolutions obtained through full investigation - no reasonable cause determinations and successful and unsuccessful conciliations. There were 41,510 determinations on the merits during the year, 61.6 percent of all resolutions. Of those, 2,973 (23.0%) were resolved through the administrative conciliation process following issuance of no reasonable cause determinations. During the year, a total of 2,721 reasonable cause findings resulted from full investigations. Some of these reasonable cause findings were among the 2,973 conciliations completed.

On-sites continued to be a major strategy in conducting full investigations. There were 11,923 on-site investigations - an agency average of 15.6 per investigator. This resulted in a ratio this year of 28.7 percent on-sites to determinations on the merits (11,923 to 41,510).

FEPA Resolutions

Approximately 28 percent of the 44,833 FEPA resolutions were merit resolutions, consisting of 16.9 percent settlements, 1.7 percent successful conciliations, 0.3 percent unsuccessful conciliations and 9.3 percent withdrawals with settlements. Another 49.4 percent were no reasonable cause resolutions, and the remaining 22.3 percent were resolved administratively.

Benefits

Monetary benefits obtained through the investigation of individually filed and systemic charges totaled \$82,018,993.

These combined benefits included \$77,033,920 from the processing of individual charges of discrimination which benefited 9,861 people for an average of \$7,812 per person.

Non-monetary benefits resulting from enforcement unit actions continued to increase. There were 59,780 people who received non-monetary benefits this year, an increase of 4,914 over the FY 1989 total of 54,866 people.

Litigation Recommendations

Another measure of the quality of investigations conducted in the field offices is the development of cases which result in presentation memoranda (PMs) forwarded to the Office of General Counsel (OGC) and the Commission for approval for litigation. The trend for increases in the number of PMs continued for the third year. According to OGC's preliminary report, field offices submitted 998 PMs in FY 1990, an increase of 94 from the 904 forwarded in FY 1989.

FMP Initiatives

FMP continued to focus field office efforts on case management initiatives through the delivery of training in case management to managers and supervisors and through the provision of technical assistance. Another aspect of FMP's on-going effort to enhance quality is conducting on-site audits of field offices. During the year, FMP staff conducted quality audits in nineteen of the twenty-four districts, reviewed charge files from three of the remaining districts, and visited two more districts to provide technical assistance.

Technical Assistance/Education Programs

Field offices continued to provide educational programs to area employers during the year in spite of budgetary constraints. Structured outreach program efforts included 61 Voluntary Assistance Program (VAP) presentations which instructed 3,307 individuals (representing 567 employers) of their rights and responsibilities under the statutes. Field offices began to answer questions from the general public, employers and advocacy groups on the ADA, and, as discussed in the Special Activities Section, developed plans for holding public hearings on upcoming ADA policy and regulations.

SIICP ACCOMPLISHMENTS

Systemic Investigations and Individual Compliance Programs (SIICP) is responsible for identifying and investigating large scale pattern and practice discrimination charges that are initiated by the Commissioners. SIICP provides technical guidance to the field offices concerning their processing of systemic pattern and practice charges. Procedural guidance to the field regarding the processing of individually filed charges is developed by SIICP and recommended to the Commission as revisions and additions to Volume I of the Compliance Manual. In coordination with FMP, SIICP conducts quality reviews in the field offices and directs the implementation of case management controls.

SIICP also provides technical assistance to state and local Fair Employment Practices Agencies (FEPAs) and develops and recommends to the Commission FEPA and Tribal Employment Rights

Organizations (TERO) contract modifications and funding principles. Monitoring the FEPA and TERO work sharing agreements is another of SIICP's operational responsibilities.

Systemic Actions Approved

The Commission approved 69 systemic case actions this year, an increase of 6.2 percent over the 65 actions in the previous year. This year's case actions included 15 final decisions on the merits. The remaining fifty-four actions consisted of one withdrawal, seven settlements, ten successful conciliations and thirty-six new charges.

Of the fifteen final decisions approved, three ended the investigations on charges filed on or before 1982. Settlements ended processing of another seven of these older cases, and together with the final decisions, ten such cases on the nation-wide systemic docket were resolved. By continuing to make progress in resolving these older cases, systemic units were able to progress further toward improving the timeliness and quality of systemic investigations.

Systemic investigations in FY 1990 resulted in a total of \$4,985,073 in benefits, including \$2,365,620 in back pay for 418 identified victims of discrimination.

FSP ACCOMPLISHMENTS

Federal Sector Programs (FSP) staff provides leadership and guidance to federal agencies on all aspects of the federal government affirmative employment programs. FSP staff also provides necessary program guidance to administrative judges (AJs) who hold hearings in EEOC field offices on

complaints against federal agencies nationwide.

Hearings

Hearings productivity per AJ rose significantly from 82.1 to 89.7 resolutions per AJ. However, due to a decrease in available AJ staff - from 68 to 58 - the total number of federal complaints resolved through hearings units declined by 7.7 percent (433 cases).

Of the 5,186 cases resolved by hearings staff, 5,072 (97.8 percent) were individual complaints, and the remaining 114 (2.2 percent of the resolutions) were class cases. There were 1,932 (37.3 percent of total resolutions) cases closed with recommended decisions and 3,140 (60.5 percent) closed without decisions. About one-half of the cases closed with recommended decisions were closed with written decisions and the other half were closed with decisions from the bench. The cases closed without recommended decisions included:

<u>No./Res.Type</u>	<u>Pct.of Total Resolutions</u>
1,620 settlements	31.2
904 remands	17.4
616 withdrawals	11.9

Field office hearings units also improved the average processing days between the date of hearing and the date of decision from 61 to 58 days.

Guidance and Information to Federal Agencies

FSP continued to provide written guidance and procedures as well as advice and technical assistance to federal

agencies on EEO complaint processing and affirmative employment. Methods for providing advice and assistance included: presentation of training to EEO Counselors at the Social Security Administration, the Department of State and the Defense Investigative Service, holding two EEO Directors' Conferences during the year to communicate new approaches, issuing an EEO counselor handbook and, throughout the year, providing assistance on specific issues as the need arose, e.g., a memorandum on "Individuals with Hearing Impairments" sent to federal agency administrators and new forms created to improve coordination between EEOC and other federal agencies.

FSP obtained Commission approval for the following publications:

- Six-Year Trend Analyses of Federal Employment of Women, Minorities, and Individuals with Disabilities for FY 1982-FY 1987, two reports used by Congress and federal agencies to monitor and formulate hiring policies.
- A Handbook for Managers and Supervisors on the Employment of People with Disabilities in the Federal Government, a handbook and training guide designed to promote understanding of the systems used in hiring people with disabilities.
- Annual Report on the Employment of Minorities, Women and People with Disabilities in the Federal government, Fiscal Year 1988, the seventh annual report on the federal employment status of minorities and women and on the federal work place environment for people with disabilities.
- Report on Pre-Complaint Counseling and Complaint Processing by Federal

Agencies for Fiscal Year 1988, an annual report on the processing of complaints of discrimination in the federal government.

Federal Sector Complaints

According to data reported in FY 1990 by other federal agencies, federal employees filed 16,174 complaints in FY 1989, an increase of 1.3 percent over the year before. Federal agencies closed 16,091 complaints, a decrease from the previous year of 9.8 percent. These agencies reported pending inventories totaling 16,146 complaints, down 1.7 percent from the 16,421 reported at the end of FY 1988.

Federal Affirmative Action

FSP headquarters staff working in conjunction with field office Federal Affirmative Action (FAA) units completed nation-wide EEO Affirmative Employment Program on-site reviews of three major federal agencies: the Department of the Navy, the General Services Administration, and the Department of Interior.

DRP ACCOMPLISHMENTS

The Determinations Review Program (DRP) allows charging parties/complainants to request a headquarters review of no reasonable cause determinations issued by EEOC field offices. DRP continued to improve its rate of productivity in FY 1990, its third full year of operation. There was an increase in the ratio of no cause determination reviews resolved to those received from 86.9 percent to 88.9 percent.

During the year, DRP received 8,733

requests for reviews of field determinations, 22.1 percent of the no reasonable cause determinations issued during the year. This was an increase of 9.9 percent over the 7,947 determinations submitted on appeal in FY 1989 (22.7 percent of the FY 1989 no reasonable cause determinations). Of the requests submitted this year, 66.8 percent involved Title VII charges, 21.2 percent ADEA, 0.1 percent EPA and 11.9 percent concurrently filed under some other combination of the three statutes.

DRP resolved 7,762 determination reviews, a 12.4 percent increase over the 6,907 reviews completed in FY 1989. Of these resolutions, 7,161 were decisions, and 92 percent (7,136) of the decisions sustained the field's no reasonable cause determination. Decisions reversed all or part of the remaining 25 field office determinations (0.3 percent of the decisions). Six hundred and one reviews were closed administratively (7.7 percent of total resolutions), through withdrawal, rejection, field office reevaluation, filing of suit, or settlement.

An additional 200 charge files (constituting 2.3 percent of FY 1990 DRP receipts) were remanded to the field offices for further investigation. Of these, 110 were closed by the end of the fiscal year and are included in the above decision figures. Eleven of the remands resulted in field office reevaluations, settlements or other forms of administrative actions taken by the field offices.

DRP Initiatives

During FY 1990, DRP initiated an up-front case review procedure which identifies certain cases as suitable for expedited review. This initiative allowed DRP to increase the ratio of resolutions to receipts, thereby making it possible to

hold the increase in pending inventory down in spite of a significant rise in the number of reviews requested during the year.

ORPP ACCOMPLISHMENTS

The Operations Research and Planning Programs (ORPP) completed its second year of operations in OPO serving as the agency's data repository for information from a variety of sources. The ORPP staff gathers information through the design and conduct of surveys of various employment sectors and through the analysis of field office performance and OPO headquarters activities. The data is utilized by ORPP to provide support for field office investigations, to develop appropriate management reports such as data summaries, projections and graphic presentations of field office performance, to conduct planning activities and to produce research studies.

Management Information Reports

ORPP accomplishments enhance OPO managers' access to accurate and complete information regarding field office performance, on the development of performance standards and on the identification of staffing and other resource needs. Significant additions to the management reports produced by ORPP were made this year including additional indicators of state and local FEP Agency performance and also an expanded report of systemic case activities that provides a break-out of case actions by type as well as more information on the age of the systemic case load. The capability for providing individual field office reports from the existing data base was also developed, making the data more widely accessible and, therefore, more useful.

A significant initiative to improve the accuracy and completeness of automated field office performance data was undertaken by ORPP this year in coordination with FMP, SIICP and with the Office of Management's Information Systems Services (ISS). Major projects for conducting hard inventories to reconcile local EEOC data bases with the Charge Data System (CDS) national data base were carried out.

Similar projects were conducted during the year to reconcile data bases between the FEPAs, the EEOC field offices and the CDS. These projects improved the quality and integrity of the data bases, and, largely as a result of these efforts, the field offices will be able to begin using their local data bases to generate the major portion of their quarterly data reports to headquarters.

Employment Indicators

During FY 1990, ORPP's surveys staff published a composite report on the representation of minorities and women in all of the employment sectors that are surveyed by the agency, Indicators of EEO - Status and Trends. This year, for the first time, ORPP was able to accept surveys data from public and private sector employers on magnetic tape and/or diskettes. This is a more efficient method of collecting the data and is less costly and more convenient for some employers.

Also, a list of all EEO-1 employers was provided to the field on diskette this year so that, in the future, the EEO-1 number and the charge data will be linked. This system will eventually provide the field with an automated cross-reference between charge files and EEO-1 employment data.

PSSS ACCOMPLISHMENTS

The Program Support Services Staff (PSSS) acts to enhance the quality of the agency's charge processing and charge and resource management. Specifically, PSSS designs, develops and delivers training, conducts special studies and provides assistance to the field offices.

In FY 1990, the PSSS training activities focusing on field operations included the completion and distribution of the Training Resources Guide, a cross-reference to available training materials, Similarly Situated, a video tape and discussion guide, and the Legal Research Guide. In addition, a five-day course, New Supervisors' Skills, was developed and a Supervisors' Handbook. PSSS also provided field offices with case management and other training materials as requested.

An EEO Counselors Handbook was developed in coordination with FSP and was distributed to EEO Counselors at three-day training courses presented at the Social Security Administration, the State Department and the Defense Investigative Services. An OPO Luchtime Discussion Series, Telephone Techniques for Secretaries, and Put It In Writing were delivered for EEOC headquarters personnel.

PSSS also participated in the headquarters training sessions on the new Americans with Disabilities Act (ADA) legislation by developing role-playing work shops and assisting with facilitation of the training sessions.

ASSS ACCOMPLISHMENTS

The Administrative Support Services Staff (ASSS) administers the OPO management

reporting system and, this year, tracked a total of 3,733 action items for headquarters and the field. This is an increase of 17.6 percent from the 3,175 items tracked last year. Of these action items, 33.0 percent (1,223) involved correspondence via the Office of the Chairman or Congress; 49 percent (1,815) were administrative reports, 12.0 percent (466) involved personnel-related items, 5.0 percent were verbal assignments from the Program Director and the remainder involved program reports.

ASSS also executed 267 OPO-wide requests for services and 226 requests for personnel actions, increases from FY 1989 of 61.8 percent and 3.2 percent respectively. ASSS also coordinated 495 assignments and responses for the Office of the Chairman.

LEADERSHIP Special Activities

OPO Office of Program Operations Principles for Leadership

We will use forward thinking and innovative approaches to bring about the behavioral changes that are necessary for top management in OPO to be recognized as distinguished leaders in EEOC. We must persevere to build OPO's distinction based on performance, innovation, and quality.

To achieve our goal of leadership, the following principles have been adopted. These principles should guide each person and should be the foundation for all decisions, initiatives, and actions we take.

Professionalism

Competent, professional people are essential to the success of OPO's mission and will be relied upon for making and implementing decisions. People are expected to assume full responsibility for their jobs and will be held accountable for the achievement of OPO objectives.

Empowerment

Establish authority and accountability at the lowest practical level. Allowing employees to make their own decisions as to when and how their assigned responsibilities will be discharged, strengthens the team concept.

Participative Management

Create and maintain a work environment that stresses mutual respect and teamwork. Include employees in the decision-making process.

Adaptability

Change is a continuous process and will occur in our environment. Flexibility and receptiveness are key elements in meeting OPO objectives.

Creativity

Change the atmosphere to stimulate people's contributions. Seek out creativity that exists within your staff.

Communication

Continue to improve communications both internally and externally. Be more attentive to explaining "why."

Efficiency

Each person must develop cost-effective strategies to carry out OPO's responsibilities.

Expertise

To maintain a high level of expertise, OPO will ensure that staff is properly trained and motivated to accomplish the mission.

OFFICE OF PROGRAM OPERATIONS - SPECIAL ACTIVITIES**OUTREACH**

In every day interactions with people in their communities, EEOC employees act as representatives of the agency. In a more formal sense, EEOC staff are called upon to represent the agency by participating in community outreach activities, providing employer groups, bar associations, elected officials, advocacy groups and the general public with information on equal employment opportunity in the work place. OPO headquarters and field managers devote extensive time to these kinds of outreach activities, as requested by groups in the community and as initiated by the field offices to disseminate information.

At the headquarters level in FY 1990, OPO management staff made numerous presentations on EEO enforcement in the public and private sectors and on current EEOC developments on employment discrimination law. The public forums addressed by staff included other federal agencies, Fair Employment Practices Agencies, inter-agency conferences, bar associations, members of the business community and other organizations throughout the country.

OPO headquarters managers also continued to participate in program-related outreach activities, providing federal agencies and private sector organizations with current information concerning developments on employment discrimination. Examples of headquarters outreach activities include the convening of two conferences for EEO Directors from other federal agencies (in January and July, 1990) to inform agencies of new federal sector approaches for affirmative employment programs and complaints processing. In addition training was provided to federal EEO counselors in courses presented at the Social Security Administration, Department of State and

Defense Investigative Service. There were 31 additional conferences and training sessions in which OPO staff participated in order to enhance cooperative relations with other federal agencies.

Events involving state and local groups included a training conference which was developed and delivered to representatives of 57 tribes at a Tribal Employment Rights Organization conference in Denver, Colorado. The annual Fair Employment Practices Agency (FEPA) conference, which was co-sponsored with Housing and Urban Development (HUD), was attended in Baltimore, Maryland, by 325 state and local executive-level employees.

Field offices continued to provide technical assistance and educational programs to area employers during the year in spite of budgetary constraints. Outreach program efforts included 61 voluntary assistance program (VAP) presentations which instructed 3,307 individuals (representing 567 employers) of their rights and responsibilities under the statutes.

During the last few months of FY 1990, OPO field offices prepared for 62 informal public meetings which were to be held in early FY 1991 on the Americans with Disabilities Act (ADA). These meetings were planned for obtaining input that would ensure the effective implementation of the ADA in July, 1992. Therefore, equal representation of employer and advocacy groups at the meetings were carefully planned so that the input would be as representative as possible of the public which would be affected by the law. In the meantime, field offices began to respond to telephone and walk-in inquiries on the ADA almost immediately after passage of the Act.

EEOC's 25TH ANNIVERSARY

On July 2, 1990, the Office of Program Operations in a joint effort with other headquarters offices held an open house in observance of EEOC's 25th Anniversary. More than 500 guests attended, including high level federal agency officials, former EEOC Commissioners and employees, officials from FEPAs around the country, top executives from various corporations and members of groups involved in civil rights issues.

OPO staff was available at the open house to discuss the various program areas and accomplishments of recent years. Also, a computerized slide show, which graphically displayed agency accomplishments over time, was designed and prepared by headquarters staff for display throughout the celebration. Similar slide shows, tailored to particular events, will be prepared and presented at future OPO activities.

EEOC field offices recognized the EEOC's 25th anniversary in various ways. Below are some examples of the field office celebrations:

- o One office hosted a luncheon which honored retired EEOC employees who had worked for the agency since its inception.
- o Another office set up a special display to provide the general public with information on EEOC's mission.
- o A 25th anniversary celebration party was hosted by another office on July 27, with guest speakers from the diverse ethnic and cultural communities in the area.

- o One office celebrated throughout the week of July 20 through 27, which was proclaimed by the local city and county officials as Equal Employment Opportunity Week. Staff discussed past effects and future projections of laws and policies enforced by EEOC, as multicultural workshops were held during the week.
- o In one office, a local TV station cooperated with one of the field offices by airing a special segment covering EEOC's progress in enforcing anti-discrimination laws over the past 25 years.
- o One of the field offices scheduled several special events throughout the month of September.

OPERATIONAL ACTIVITIES

District Directors were called in by the Program Director and the Directors of Field Management Programs two days prior to the annual state and local FEP Agency conference, which was held in coordination with the Housing and Urban Development Department in Baltimore, Maryland during the first week of March, 1990. A full agenda of operational and administrative matters was covered during the two-day meeting.

SPECIAL EVENT

"You are invited to the White House..."

Several OPO employees were pleased to be among the EEOC headquarters employees who were randomly selected to

receive personal invitations from the White House to attend the ceremony when President George Bush signed the newly enacted Americans with Disabilities Act (ADA) into law.

The ceremony was held on the south lawn of the White House and EEOC's Chairman, Evan J. Kemp, Jr., was the moderator. This was a special day for the entire agency, and the staff members who received invitations welcomed the opportunity to observe the formal beginning of actions related to this important new law.

EEOC/FEPA RECEIPTS TO PROCESS

RECEIPTS TO PROCESS	FISCAL YEAR 1986			FISCAL YEAR 1987			FISCAL YEAR 1988			FISCAL YEAR 1989		
	TOTAL	PCT	CHANGE 85-86	TOTAL	PCT	CHANGE 86-87	TOTAL	PCT	CHANGE 87-88	TOTAL	PCT	CHANGE 88-89
TOTAL	116,487	100%	-0.2%	115,506	100%	-3.3%	117,936	100%	2.1%	108,406	100%	-8.1%
EEOC	65,066	56%	-2.2%	62,074	54%	-5.5%	58,853	50%	-5.2%	55,952	52%	-4.9%
FEPA	53,801	46%	2.3%	53,482	46%	-0.6%	59,083	50%	10.5%	52,454	48%	-11.2%

EEOC RECEIPTS TO PROCESS BY STATUTE

RECEIPTS TO PROCESS	FY 86*	% TOTAL	FY 87	% TOTAL	FY 88	% TOTAL	FY 89	% TOTAL
TOTAL	68,822	100.0%	62,074	100.0%	58,853	100.0%	55,952	100.0%
TITLE VII	50,110	72.8%	45,401	73.1%	42,657	72.6%	39,975	71.4%
ADEA	17,443	25.3%	15,121	24.4%	14,882	25.3%	14,789	26.4%
EPA	1,266	1.8%	1,267	2.0%	1,185	2.0%	1,075	1.9%
OTHER	0	0.0%	285	0.5%	159	0.3%	113	0.2%

In FY89 - FY90, receipts by statute were compiled based on receipts to process. In FY86 on total receipts.

Percent totals may not always equal 100% due to rounding.

RESOLUTIONS BY TYPE

RESOLUTIONS BY TYPE	FISCAL YEAR 1986			FISCAL YEAR 1987			FISCAL YEAR 1988			FISCAL YEAR 1989			FISCAL YEAR 1990		
	TOTAL	PCT	CHANGE 85-86	TOTAL	PCT	CHANGE 86-87	TOTAL	PCT	CHANGE 87-88	TOTAL	PCT	CHANGE 88-89	TOTAL	PCT	CHANGE 89-90
TOTAL RESOLUTIONS	63,446	100.0%	-0.2%	53,482	100.0%	-15.7%	70,749	100.0%	32.3%	66,209	100.0%	-6.4%	67,415	100.0%	1.8%
MERIT RESOLUTIONS	9,813	15.2%	-12.1%	8,114	15.2%	-15.6%	10,641	15.0%	31.1%	11,156	16.8%	4.8%	12,680	18.1%	15.5%
SETTLEMENTS*	4,601	7.3%	-19.6%	3,715	6.9%	-19.3%	4,750	6.7%	27.9%	5,420	8.2%	14.1%	5,588	8.3%	3.1%
WTHDRWLS WITH BENEFITS*	3,149	5.0%	-3.3%	2,987	5.6%	-5.1%	3,953	5.6%	32.3%	3,795	5.7%	-4.0%	4,319	6.4%	13.8%
UNSUCCESSFUL CONCILIATION	1,368	2.2%	-15.6%	1,038	1.9%	-24.3%	1,512	2.1%	45.9%	1,450	2.2%	-4.1%	2,401	3.6%	65.6%
SUCCESSFUL CONCILIATIONS	495	0.8%	49.1%	376	0.7%	-24.0%	426	0.6%	13.3%	491	0.7%	15.3%	572	0.8%	16.5%
NO REASONABLE CAUSE	37,014	58.3%	5.3%	29,578	55.3%	-20.1%	35,148	49.7%	18.8%	35,896	54.2%	2.1%	38,537	57.2%	7.4%
ADMINISTRATIVE CLOSURES	15,578	24.6%	-5.1%	15,790	29.5%	1.4%	24,900	35.3%	58.1%	19,157	28.9%	-23.2%	16,908	23.7%	-16.5%
INTAKE	1,243	2.0%	NA*	0	0.0%	NA	0	0.0%	NA	0	0.0%	NA	0	0.0%	NA

* Prior to FY 87 charges were resolved by intake units.

Percent totals may not always equal 100% due to rounding.

MERIT RESOLUTIONS BY TYPE

MERIT RESOLUTIONS BY TYPE	FISCAL YEAR 1986			FISCAL YEAR 1987			FISCAL YEAR 1988			FISCAL YEAR 1989			FISCAL YEAR 1990		
	TOTAL	PCT	CHANGE 85-86	TOTAL	PCT	CHANGE 86-87	TOTAL	PCT	CHANGE 87-88	TOTAL	PCT	CHANGE 88-89	TOTAL	PCT	CHANGE 89-90
MERIT RESOLUTIONS	9,813	16.2%	-12.1%	8,114	15.2%	-16.0%	10,641	15.0%	31.1%	11,156	16.6%	4.8%	12,880	18.1%	15.5%
SETTLEMENTS*	4,801	7.3%	-19.8%	3,716	6.9%	-19.3%	4,750	6.7%	27.9%	5,420	8.2%	14.1%	5,568	8.3%	3.1%
WTHDRWL6 WITH BENEFITS**	3,148	5.0%	-3.3%	2,987	5.6%	-5.1%	3,953	5.6%	32.3%	3,795	5.7%	-4.0%	4,318	6.4%	13.9%
UNSUCCESSFUL CONCILIATIONS	1,368	2.2%	-15.6%	1,036	1.9%	-24.3%	1,512	2.1%	45.9%	1,450	2.2%	-4.1%	2,401	3.6%	65.0%
SUCCESSFUL CONCILIATIONS	495	0.8%	49.1%	376	0.7%	-24.0%	426	0.6%	13.3%	481	0.7%	16.3%	572	0.8%	18.5%
TOTAL RESOLUTIONS	63,448		-0.2%	63,482		-16.7%	70,749		32.3%	66,209		-6.4%	67,418		1.8%

Percent totals may not always equal 100% due to rounding.

RESOLUTIONS BY STATUTE

RESOLUTIONS BY STATUTE	FY 88	% TOTAL	FY 87	% TOTAL	FY 88	% TOTAL	FY 89	% TOTAL	FY 90	% TOTAL
TOTAL	63,446	100.0%	53,482	100.0%	70,749	100.0%	66,209	100.0%	67,415	100.0%
TITLE VII	45,506	71.7%	37,691	70.5%	49,895	70.2%	47,621	71.9%	49,612	73.6%
ADEA	14,933	23.5%	14,530	27.2%	19,427	27.5%	16,989	25.7%	16,269	24.1%
EPA	1,630	2.6%	1,122	2.1%	1,466	2.1%	1,454	2.2%	1,385	2.0%
OTHER	134	0.2%	139	0.3%	161	0.2%	145	0.2%	169	0.3%
INTAKE	1,243	2.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Percent totals may not always equal 100% due to rounding.

DETERMINATIONS ON MERITS

DETERMINATIONS ON MERITS	% CHANGE		% CHANGE		% CHANGE		% CHANGE		% CHANGE	
	FY 86	85-86	FY 87	86-87	FY 88	87-88	FY 89	88-89	FY 90	89-90
TOTAL	38,877	4.8%	30,990	-20.3%	37,086	16.7%	37,837	2.0%	41,610	9.7%
CAUSE	1,863	-4.6%	1,412	-24.2%	1,938	37.3%	1,941	0.2%	2,973	63.2%
NO REASONABLE CAUSE	37,014	5.3%	29,578	-20.1%	35,148	18.8%	35,896	2.1%	38,637	7.4%

INVESTIGATOR PRODUCTIVITY

PRODUCTIVITY	% CHANGE		% CHANGE		% CHANGE		% CHANGE		% CHANGE	
	FY 86	85-86	FY 87	86-87	FY 88	87-88	FY 89	88-89	FY 90	89-90
RESOLUTIONS PER INVESTIGATOR	88.3	2.0%	78.4	-9.2%	80.4	2.6%	79.0	-1.7%	88.4	11.9%

Percent totals may not always equal 100% due to rounding.

EEOC RECEIPTS TO PROCESS, RESOLUTIONS, PENDING INVENTORY

	% CHANGE		% CHANGE		% CHANGE		% CHANGE			
	FY 88	85-88	FY 87	86-87	FY 88	87-88	FY 89	88-89	FY 90	89-90
RECEIPTS TO PROCESS	65,666	2.2%	62,074	-5.5%	58,853	-8.2%	55,982	-4.9%	50,426	6.2%
TOTAL RESOLUTIONS	63,448	0.2%	53,482	-15.7%	70,749	32.3%	66,209	-6.4%	67,415	1.8%
PENDING INVENTORY	50,767	8.6%	61,686	21.5%	53,780	-12.8%	46,071	-14.3%	41,987	-8.9*

* Pending Inventory was reduced in FY90 in spite of an increase in receipts to process due to the continuing high ratio (1.13) of resolutions to receipts to process.

Percent totals may not always equal 100% due to rounding.

Enforcement Monetary Benefits and Total People Benefitted

ENFORCEMENT MONETARY BENEFITS	% CHANGE		% CHANGE		% CHANGE		% CHANGE		% CHANGE	
	FY 86	85-86	FY 87	86-87	FY 88	87-88	FY 89	88-89	FY 90	89-90
TOTAL MONETARY BENEFITS	\$53,816,000	-32.3%	\$48,430,000	-9.8%	\$85,783,000	35.8%	\$77,478,000	17.8%	\$77,034,000	-0.6%
PEOPLE BENEFITED MONETARILY	12,889	3.3%	6,500	-57.3%	8,007	57.5%	12,187	40.0%	9,861	-19.1%

Total Monetary Benefits

MONETARY BENEFITS	% CHANGE		% CHANGE		% CHANGE		% CHANGE		% CHANGE	
	FY 86	85-86	FY 87	86-87	FY 88	87-88	FY 89	88-89	FY 90	89-90
TOTAL	\$54,020,000	-31.8%	\$51,069,000	-5.5%	\$75,401,000	47.6%	\$91,363,000	21.2%	\$82,019,000	-10.2%
ENFORCEMENT	\$53,516,000	-32.3%	\$48,430,000	-9.5%	\$85,783,000	35.8%	\$77,478,000	17.8%	\$77,034,000	-0.6%
SYSTEMIC	\$504,000	N/A	\$2,639,000	423.6%	\$8,618,000	294.5%	\$13,885,000	44.4%	\$4,985,000	-64.1%

Percent totals may not always equal 100% due to rounding.

SYSTEMIC CASE ACTIONS

SYSTEMIC	% CHANGE		% CHANGE		% CHANGE		% CHANGE		% CHANGE	
	FY 86	85-86	FY 87	86-87	FY 88	87-88	FY 89	88-89	FY 90	89-90
TOTAL ACTIONS	28	NA	30	7.1%	51	70.0%	65	27.5%	69	6.2%

Percent totals may not always equal 100% due to rounding.

SYSTEMIC CASE ACTIONS BY TYPE

CASE ACTIONS BY TYPE	FISCAL YEAR 1989		FISCAL YEAR 1990	
	TOTAL	PCT	TOTAL	PCT
TOTAL CASE ACTIONS	65	100.0%	69	100.0%
RESOLUTIONS	43	66.2%	33	47.8%
SETTLEMENTS	9	13.8%	7	10.1%
CONCILIATIONS	11	16.9%	10	14.5%
UNSUCCESSFUL CONCILIATIONS	10	15.4%	7	10.8%
NO CAUSE	10	15.4%	8	11.8%
WITHDRAWALS	3	4.6%	1	1.5%
NEW CHARGES	17	26.2%	36	52.2%
* ADEA DIRECTED	6	7.7%	0	0.0%

* ADEA case actions do not require Commission approval.

Percent totals may not always equal 100% due to rounding.

DETERMINATIONS REVIEW PROGRAM

DRP	1988	% CHANGE		% CHANGE	
		1989	88-89	1990	89-90
RECEIPTS	8,604	7,947	-7.6%	8,733	9.0%
RESOLUTIONS	5,495	6,907	25.7%	7,762	12.4%
PENDING INVENTORY	3,374	4,414	30.8%	5,376	21.8%

Percent totals may not always equal 100% due to rounding.

DRP RESOLUTIONS BY TYPE

RESOLUTIONS BY TYPE	FISCAL YEAR 1989		FISCAL YEAR 1990	
	TOTAL	PCT	TOTAL	PCT
ADMINISTRATIVE RESOLUTIONS	528	7.6%	801	7.7%
WITHDRAWALS	47	0.7%	56	0.7%
REQUESTS REJECTED	432	6.3%	462	6.0%
REEVALUATIONS	0	0.1%	7	0.1%
SETTLEMENTS	17	0.2%	29	0.6%
SUITS FILED	23	0.3%	47	0.4%
DECISIONS	6,379	92.4%	7161	92.3%
SUSTAINED	6,317	91.6%	7138	91.9%
REVERSED	66	0.8%	22	0.3%
MIXED	6	0.1%	3	0.0%
TOTAL RESOLUTIONS	6,907	100.0%	7762	100.0%
REMANDS	231	NA	200	NA

Percent totals may not always equal 100% due to rounding.

PRESENTATION MEMORANDA, LITIGATION AUTHORIZED, SUITS FILED

LITIGATION	% CHANGE		% CHANGE		% CHANGE		% CHANGE		% CHANGE	
	FY 86	85-86	FY 87	86-87	FY 88	87-88	FY 89	88-89	FY 90	89-90
PMs	701	-1.0%	557	-20.5%	764	37.2%	904	18.3%	906	10.4%
AUTHORIZED	440	58.8%	436	-0.9%	482	10.6%	482	0.0%	689	42.9%
SUITS FILED	526	28.0%	527	0.2%	555	5.3%	598	7.7%	640	7.0%

PMs and Litigation Authorized are based on OGC records.

Percent totals may not always equal 100% due to rounding.

HEARINGS ANNUAL RESOLUTIONS BY TYPE

HEARINGS RESOLUTIONS BY TYPE	FY 86		FY 87		FY 88		FY 89		FY 90	
	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL
TOTAL RESOLUTIONS	5,191	100.0%	5,047	100.0%	6,227	100.0%	6,616	100.0%	5,188	100.0%
RECOMMENDED DECISIONS	1,916	36.9%	1,707	33.8%	2,222	35.7%	2,214	39.4%	1,932	37.3%
SETTLEMENTS	1,423	27.4%	1,453	28.8%	1,885	30.3%	1,663	27.9%	1,620	31.2%
WITHDRAWALS	742	14.3%	795	15.8%	926	14.9%	724	12.9%	616	11.9%
REMANDS	1,016	19.6%	1,006	20.0%	1,052	16.9%	988	17.9%	904	17.4%
CLASS	94	1.8%	84	1.7%	142	2.3%	128	2.3%	114	2.2%

HEARINGS PRODUCTIVITY

HEARINGS PRODUCTIVITY	% CHANGE		% CHANGE		% CHANGE		% CHANGE			
	FY 86	85-86	FY 87	86-87	FY 88	87-88	FY 89	88-89		
RESOLUTIONS PER ADMINISTRATIVE JUDGE	71.1	2.4%	73.0	2.7%	82.0	12.3%	82.1	0.1%	89.7	9.3%

Percent totals may not always equal 100% due to rounding.

FEDERAL HEARINGS RECEIPTS, RESOLUTIONS, PENDING INVENTORY

HEARINGS	% CHANGE		% CHANGE		% CHANGE		% CHANGE		% CHANGE	
	FY 86	85-86	FY 87	86-87	FY 88	87-88	FY 89	88-89	FY 90	89-90
RECEIPTS	5,258	2.6%	5,045	-4.1%	5,278	4.6%	5,183	-1.8%	5,417	4.6%
RESOLUTIONS	5,191	1.1%	5,047	-2.8%	6,227	23.4%	5,619	-9.8%	5,188	-7.7%
INVENTORY	3,959	3.6%	3,929	-0.8%	2,851	-32.5%	2,159	-18.6%	2,421	12.1%

Percent totals may not always equal 100% due to rounding.

FEDERAL COMPLAINTS RESOLUTIONS BY TYPE

FEDERAL COMPLAINTS RESOLUTIONS BY TYPE	FY 85 % TOTAL		FY 86 % TOTAL		FY 87 % TOTAL		FY 88 % TOTAL		FY 89 % TOTAL	
	TOTAL RESOLUTIONS	18,337	100.0%	17,962	100.0%	17,014	100.0%	17,844	100.0%	18,001
REJECTIONS	2,494	13.6%	2,572	14.3%	2,668	15.7%	3,178	17.8%	2,525	15.7%
CANCELLATIONS	1,819	8.8%	1,701	9.5%	1,575	9.3%	1,768	9.9%	1,674	10.4%
WITHDRAWALS	3,431	18.7%	3,057	17.0%	3,519	20.7%	2,758	15.5%	2,381	14.9%
SETTLEMENTS	5,747	31.3%	5,458	30.4%	4,828	28.4%	5,346	30.0%	4,738	29.4%
AGENCY DECISIONS	5,046	27.5%	5,179	28.8%	4,424	26.0%	4,794	28.0%	4,765	29.8%

FEDERAL COMPLAINTS RECEIPTS, RESOLUTIONS, PENDING INVENTORY

FEDERAL SECTOR	% CHANGE		% CHANGE		% CHANGE		% CHANGE	
	FY 88	85-86	FY 87	86-87	FY 88	87-88	FY 89	88-89
RECEIPTS	18,167	-0.3%	15,931	-12.3%	15,972	0.3%	18,174	1.3%
CLOSURES	17,902	-2.0%	17,014	-5.3%	17,844	4.9%	18,091	-0.8%
PENDING	19,032	-0.1%	18,221	-4.3%	18,421	-0.9%	18,148	-1.7%

Percent totals may not always equal 100% due to rounding.

ITEM 19. FEDERAL COMMUNICATIONS COMMISSION

DECEMBER 9, 1991.

DEAR CHAIRMAN PRYOR: Thank you for your letter of October 2, 1991, requesting a summary of actions affecting the elderly taken by the Federal Communications Commission during fiscal year 1990. I understand that this summary will be included in your publication, *Developments in Aging*.

We have made significant progress in reaching the July 1993 deadline legislated by the Americans With Disabilities Act of 1990. Telecommunications relay services, which must enable people with hearing and/or speech disabilities to fully access the general telephone network, are in operation in approximately 30 States, and these services will be extended to all 50 States and U.S. territories by the deadline.

The Commission also adopted rules governing closed-captioned television transmissions, which serve the needs of the deaf and hearing-impaired. This circuitry, under provisions of the Television Decoder Circuitry Act of 1990, must be present in most television receivers manufactured or imported for use in the United States by July 1, 1993.

Finally, the Federal Communications Commission Authorization Act of 1990 allows this agency to employ older Americans and thereby make use of one of this country's significant human resources. In October 1991 a cooperative agreement was signed with the National Council on the Aging, Inc., to allow us to fill critical shortage positions with older Americans.

Thank you for providing us this opportunity to report on our activities affecting the elderly.

Sincerely,

ALFRED C. SIKES,
Chairman.

Enclosure.

SUMMARY OF FEDERAL COMMUNICATIONS COMMISSION ACTIVITIES AFFECTING THE ELDERLY

The Federal Communications Commission has engaged in a number of activities which should positively affect America's elderly. For example, the Commission continues to work with Congress and the administration to implement legislation to ensure that speech and hearing-impaired persons, including the elderly, have reasonable access to the telephone network.

The Commission, on July 26, 1991, adopted and released a Report and Order in CC Docket 90-571 which established minimum operational, functional, and technical standards with which telecommunications relay services in America must comply to enable people with hearing and/or speech disabilities to fully access the general telephone network. The Report and Order was a compilation of over 70 comments and replies received from common carriers, trade associations, organizations serving people with disabilities, and State utility commissions. Telecommunications relay services, although already in operation in approximately 30 States, will be extended to all 50 States and U.S. territories by July 1993, the deadline legislated by the Americans with Disabilities Act of 1990 (P.L. 101-336). The ADA was signed into law on July 26, 1990, and it mandated the Commission to ensure that all common carriers establish a telecommunications relay service within 3 years of its passage.

On August 7, 1991, the Commission issued a Memorandum Opinion and Order, CC Docket 87-124, which denied a petition for reconsideration that all credit card and common area telephones be hearing-aid compatible. The Commission is planning to take action in a further rulemaking which will retrofit telephones in the workplace, hotels and motels, hospitals, residential health care facilities for senior citizens, convalescent homes, and prisons. These regulatory efforts were mandated by passage of the Hearing Aid Compatibility Act of 1988, Public Law 100-394, on August 17, 1988. This law requires most telephones manufactured in or imported into the United States more than 1 year after its enactment to be hearing aid compatible.

On April 12, 1991, the Commission adopted television decoder rules that set performance and display standards, as well as marketing regulations, for circuitry that is required to be built into television receivers in order to display closed-captioned television transmissions. These rules are adopted in response to the provisions of the Television Decoder Circuitry Act of 1990 (P.L. 101-434), which requires that most television receivers manufactured or imported for use in the United States be equipped with such circuitry by July 1, 1993. The rules are intended to serve the needs of the deaf, hearing-impaired, and others by expanding the accessibility of closed-caption technology.

The Commission is currently considering a Petition for Reconsideration, requesting certain relatively minor technical changes and further guidance on the requirements that television decoders be compatible with cable television security systems.

The Federal Communications Commission Authorization Act of 1990 (P.L. 101-136), signed September 28, 1990, extended the Commission's authority to participate in the older Americans program. On October 18, 1991, the FCC and the National Council on Aging (NCOA) signed a cooperative agreement to launch a pilot program enlisting older workers to perform critical engineering work for the Commission. This is work which would otherwise not be accomplished in an acceptable time-frame due to the unavailability of qualified Federal employees for short-term, temporary assignments. The agreement will be in effect through fiscal year 1992 only, with the possibility of renewal should it prove to be successful.

The FCC has taken several steps in the Subscriber Line Charge (SLC) proceeding, based on the recommendations of an advisory group of Federal and State regulators, to assist low and fixed income telephone subscribers. These measures include high cost assistance designed to keep local exchange rates lower than they otherwise would be in certain parts of the Nation. As a result of the SLC program and other actions, direct dial interstate toll rates have dropped approximately 45 percent since May 1984. A January 1989 study by Southwestern Bell further demonstrates the value of these rate reductions to the elderly. The study shows that senior citizens have increased their long distance usage 92.6 percent since 1983 (before SLCs were in effect). This was well above the average residential subscriber's usage increase of 72.2 percent.

The Commission also has implemented a Federal lifeline program to reduce telephone charges for low income subscribers. Under this program, local telephone companies are able to waive the subscriber line charge for low-income subscribers qualifying under specified State assistance programs when the certified State or local telephone company makes an equal monetary contribution to reduce local exchange rates for these customers. Based on the current \$3.50 subscriber line charge, qualifying subscribers can receive up to a total of \$7 per month in assistance. The lifeline assistance program is funded through usage-based charges paid by the long distance companies. To date, local telephone companies in 34 States, the District of Columbia, and the Virgin Islands have federally approved lifeline programs, and local telephone companies in 49 States, the District of Columbia, Puerto Rico and the Virgin Islands have federally approved connection assistance programs. Most local telephone companies also offer budget rate measured service.

On April 16, 1987, the Commission, in coordination with the American Association of Retired Persons and the Consumers Federation of America, introduced a connection assistance program called "Link-up America," which provides a discount of 50 percent—up to \$30—for connection charges to low-income households seeking telephone service. The FCC estimates that approximately 3 million low-income households, including many elderly, are eligible for assistance under the program. In addition, telephone companies are encouraged to offer interest free deferred payment schedules on the remaining balance and, where appropriate, to reduce or to waive any deposit that may be required.

In addition, the Commission continues to monitor telephone penetration rates for the elderly as well as other segments of the population. Census Bureau data collected at the request of the FCC show that telephone subscribership has increased or remained stable since divestiture, even in the case of the unemployed and those with extremely low-income levels. In fact, the Census Bureau data for July 1991 (the most recent information currently available) show that 93.3 percent of American households have telephone service in their homes compared to 91.4 percent in November 1983, just prior to divestiture.

The elderly in all income brackets have telephone subscribership levels that are significantly higher than those for households headed by younger people. The July 1991 census data indicated that 95.9 percent of household headed by a person between 60 and 64 years of age has a telephone at home compared to a 93.3 percent subscribership level for all households. Based on the July 1991 census data, 96.4 percent of households headed by someone between the ages of 65 and 69 subscribed to telephone service, while households headed by someone from 70 to 99 years of age had a subscribership rate of 97 percent. Subscribership levels for these groups have increased or remained stable since divestiture.

On May 24, 1991, the Commission proposed to amend Part 15 rules by expanding the frequency bands in which nonlicensed auditory assistance devices are permitted to operate. This action, in ET Docket No. 91-50, was taken in response to a petition filed by Phonic Ear, Inc. The objective of this proposal is to improve the ability of

educational institutions, as well as places of public gathering, to provide auditory assistance to persons with hearing impairments.

ITEM 20. FEDERAL TRADE COMMISSION

DECEMBER 13, 1991.

DEAR MR. PRYOR: In response to your letter of October 2, 1991, I am pleased to forward the annual staff summary of Federal Trade Commission activities affecting older consumers for the year 1991. As this summary indicates, many of the Commission's efforts to police the market for unfair or deceptive practices and to promote a competitive market are particularly significant for older consumers.

I hope this information will be helpful to the Committee. Please let me know if we can provide any further assistance.

By direction of the Commission.

JANET D. STEIGER,
Chairman.

Enclosure.

STAFF SUMMARY OF FEDERAL TRADE COMMISSION ACTIVITIES AFFECTING OLDER CONSUMERS

This report discusses the Federal Trade Commission's activities on behalf of older consumers in FY 1991 and also includes relevant information up to December 1991. The first section of the report describes those activities addressing the health concerns of older consumers. Persons over age 65 spend almost three times more per capita on health care than other adults. The second section describes Commission law enforcement initiatives in 1991 outside the health field that are of particular importance to older consumers. The final section describes the Commission's relevant consumer education activities.

HEALTH-RELATED ACTIVITIES

HOSPITAL SERVICES

Older consumers make greater use of health care facilities, including hospitals, than other segments of the population. Thus, as a group, they stand to benefit more from effective competition among health care providers.

In April 1991, the Commission successfully challenged a proposed hospital merger in Augusta, GA, that would have combined the largest general acute care hospital in that city with one of only four competitors. A Federal court preliminarily enjoined the merger, agreeing with the Commission that the merger created a substantial danger of higher hospital prices and lower quality of care. The Commission also issued an administrative complaint that is pending before an administrative law judge.

The Commission is continuing its litigation against a merger of two general acute care hospitals in Ukiah, CA. The Commission's administrative complaint charges that the merger gave one company control of three of the five general hospitals in the Ukiah area, and that the resulting dominant position in the local hospital market likely would deny consumers competitive prices and quality hospital care. This case is in pre-trial proceedings before an administrative law judge.

The staff of the Commission has also investigated several other hospital mergers in the past year, usually involving hospitals serving heavily populated metropolitan areas. In one of these matters, a proposed merger of two of the seven general hospitals in a metropolitan area in the South, the merger was abandoned while the staff of the Commission was conducting its investigation.

FUNERAL HOMES

The staff of the Commission continues to monitor mergers and acquisitions in the funeral industry. Funeral services are likely to be of particular concern to older persons.

In 1991, the Commission challenged three funeral home mergers that allegedly would have anticompetitive effects in markets in Georgia, Arkansas, Tennessee, and California. One of the cases, Sentinel's acquisition of several independent funeral homes in Georgia and Arkansas, has been settled on terms that require the divestiture of a number of funeral homes in markets where the merger allegedly would enhance the possibility of collusion among the remaining firms in those areas. In a second merger, the Commission has accepted a consent order for public comment to

settle allegations that Service Corporation International's (SCI's) acquisition of Sentinel would enhance the possibility of collusion among the remaining firms in locations in Georgia and Tennessee. In the third merger, the Commission has accepted a consent agreement for public comment to settle allegations that SCI's acquisition of Pierce Brothers could lead to a dominant firm in the Riverside/San Bernardino region of California.

NURSING HOMES

The staff to the Commission also monitors mergers and acquisitions in the nursing home industry. Such transactions, when they leave consumers in a particular area with few competitors to choose from, may add to the difficulties many older consumers already face in trying to obtain high-quality nursing home care at prices they and their families can afford.

HOME HEALTH CARE

Home health care services offer the possibility to reduced health care expenses and can enable some people who would otherwise require institutional care to remain at home. Durable medical equipment often is an important component of effective home health care. The staff of the Commission investigated potentially anticompetitive mergers or proposed mergers among producers of such medical equipment.

In May 1991, the Commission issued its complaint and consent order settling a challenge to a consummated merger between American Stair-Glide and Cheney, the country's largest producers of curved and straight stairlifts, vertical wheelchair lifts, and other accessibility equipment. The consent order requires the respondents to grant a nonexclusive perpetual license of technology for the production of the relevant products and to provide necessary technological assistance to a licensee approved by the Commission. In addition, for 5 years, the respondents may not enter into long-term sales or distribution agreements, or exclusive agreements limiting distributors' ability to sell the relevant products of any other manufacturer, and may not condition the sale of products or the provision of services on any distributor not selling the relevant products of any other manufacturer.

PHYSICIAN JOINT VENTURES

The staff of the Commission is investigating possible anti-competitive joint ventures by physicians involving their referral of patients to, and their operation of, medical technology in which the physicians have an ownership interest.

PHYSICIANS AND THIRD-PARTY PAYORS

In June 1991, the staff of the Commission sent written comments to the General Accounting Office on a GAO report concerning the relationship between physicians and third-party payors. The staff agreed with GAO's conclusion that legislation is not needed to provide antitrust immunity for health care providers to use peer review to effectuate cost containment procedures.

PRESCRIPTION DRUGS

One way of keeping medicines affordable is to preserve competition in the pharmaceutical industry. To that end, the staff of the Commission monitors mergers and acquisitions in the pharmaceutical industry and challenges those that appear to be anticompetitive. In September 1991, the staff of the Commission investigated an acquisition involving two companies that make soft gelatin capsules (softgels). Softgels are used for prescription pharmaceuticals, over-the-counter drugs, vitamins and other nutritional products. The acquisition was abandoned after the Commission requested additional information about the proposed merger.

In FY 1991, the Commission issued nine consent orders settling charges that pharmacy firms and associations had engaged in a boycott of a New York State health care plan that provided pharmacy benefits to State employees, both current and retired. The Commission complaints alleged that the boycott was aimed at forcing the State to increase the plan's payments to pharmacies, which would raise the State's health care costs. In administrative litigation against one pharmacy chain that has not settled, the administrative law judge determined in June 1991 that the pharmacy chain's practices constituted a boycott.

The staff of the Commission also is investigating an allegation that pharmacies and a pharmacy association in Colorado boycotted the State's prescription drug pro-

gram for retired employees. Such a boycott could result in higher out-of-pocket expenses for retirees whose pharmacy benefits are provided through the program.

The staff of the Commission also investigated, and in some cases is continuing to investigate, other anticompetitive practices that could raise the price of drugs for older persons. In one matter, the staff of the Commission is investigating allegations that two biotech-pharmaceutical companies may have allocated markets for a new drug through a patent cross-licensing agreement. In 1991, the staff of the Commission also investigated allegations of exclusive dealing in the supply of the essential ingredient in an anticancer drug. The staff of the Commission is also investigating an alleged solicitation to fix the prices of prescription drugs by two retail chain stores.

In another matter, the Commission in June 1991 accepted, subject to final approval, a consent agreement settling charges that Sandoz Pharmaceuticals Corporation illegally tied the sale of its antischizophrenic drug Clozaril to the sale of patient monitoring services. The consent agreement, if finalized, would prohibit Sandoz from requiring purchasers of Clozaril to purchase monitoring services from Sandoz or its designee. The consent agreement would permit providers other than Sandoz's designee to provide monitoring systems for Clozaril, so that consumers may be able to obtain the monitoring for lower prices. Other purchasers, such as the Veterans' Administration, would be able to provide the required patient monitoring on their own, thereby potentially cutting the previous cost of Clozaril, which came to almost \$9,000 per person per year.

The staff of the Commission also is investigating an alleged sham petition before a regulatory agency and the courts to restrict a competitor from entering a highly concentrated market for important medical supplies. Restricting entry into that market likely would harm consumers by limiting the choices of hospitals and doctors and diminishing price and quality competition. In addition, the staff of the Commission is investigating allegations of price discrimination by a manufacturer of prescription drugs.

In appropriate circumstances, the staff of the Commission offers comment on State laws and regulations potentially affecting the prices that older consumers pay for drugs. In April 1991, the staff of the Commission commented to the Commerce and Regulated Professions Committee of the General Assembly of New Jersey concerning a proposed bill to govern the dispensing and sale of drugs or medicines by physicians. The comments pointed out that any legislation that unnecessarily restricts physician dispensing may deprive consumers of the benefits of choice, convenience, and price competition.

The staff of the Commission also provided the New York legislature with written comments regarding a bill that would have circumscribed a physician's ability to dispense prescription drugs in competition with pharmacists. The comments noted that the bill could deprive consumers of the convenience of one-stop shopping for medical care, a convenience that may be of particular significance to many older persons.

VISION CARE

In March 1989, the Commission promulgated a rule that would have invalidated four types of State restrictions on the commercial practice of optometry (Eyeglasses II Rule). The basis for the rule was that removal of these restrictions would stimulate competition in the vision care industry and allow consumers to purchase vision care goods and services at lower prices without any compromise in the quality of care that consumers receive. In August 1990, the U.S. Court of Appeals for the District of Columbia vacated the rule, construing the FTC Act as not granting the Commission the authority to promulgate the rule. This decision was not appealed to the Supreme Court. The Commission continues to pursue other alternatives to help increase competition in this industry.

The pre-existing Eyeglasses I Rule remains in effect, requiring that optometrists and ophthalmologists give consumers copies of their eyeglass prescriptions after an eye examination. This rule helps consumers pay lower prices by facilitating comparison-shopping for eyewear.

The staff of the Commission also is investigating a merger of two firms that produce laser technology used in the correction of vision problems.

PHYSICIAN SERVICES

In September 1991, the Commission accepted, subject to final approval, a consent agreement settling charges that physicians in Jacksonville, FL, illegally conspired to fix the fees they charged to third-party payors, and to boycott or threaten to boy-

cott third-party payors. The consent agreement, if approved as final by the Commission, would mark the first time that a settlement agreement required dissolution of a health care organization charged with price fixing. A related investigation remains open.

In September 1991, the Commission issued consent orders settling charges that physicians at Holy Cross Hospital and at Broward Medical Center in Fort Lauderdale, FL, had conspired to threaten to boycott their respective hospitals in order to coerce the hospitals not to enter a business relationship with the Cleveland Clinic, which provides specialized care including organ transplants, and not to grant privileges to Cleveland Clinic physicians.

In 1991, the staff also conducted preliminary investigations of allegations that doctors organized boycotts in order to reduce competition and increase prices.

CHIROPRACTIC SERVICES

The staff of the Commission is investigating whether an association of chiropractors has engaged in price fixing.

PODIATRY SERVICES

Consumers, for quality-of-care or price reasons, sometimes prefer to purchase foot-care services from podiatrists rather than physicians. The staff of the Commission is investigating charges that physicians have excluded podiatrists from the medical staffs of some hospitals with the purpose and effect of keeping podiatrists from being effective competitors for surgical procedures.

RESTRAINTS ON ADVERTISING BY HEALTH CARE PROFESSIONALS

Advertising by professionals in general, and by health care providers in particular, has grown tremendously since the mid-1970's. The Commission supports the right of professionals to advertise truthfully. However, the Commission also recognizes the importance of policing the marketplace to ensure that health care professionals and associations do not engage in deceptive or misleading advertising practices.

In November 1991, the Commission issued a consent order that prohibits the State association of chiropractors in Connecticut from restricting truthful, nondeceptive advertising. The consent order also settles charges that the association unreasonably restrained competition by prohibiting its members from, among other things, advertising offers to provide services at discounted fees or for free. The staff of the Commission also has investigated advertising restrictions by other health care professional associations.

Finally, the staff of the Commission commented in November 1990 to the Florida Office of the Auditor General concerning the possible restrictive or anticompetitive effects of the State's statutes or regulations governing the Board of Medicine and other regulatory bodies. The comment observed that certain statutory provisions relating to physician referrals for fees could interfere with the flow of useful, nondeceptive information to consumers about medical providers by prohibiting such referrals.

FOOD, DRUG, AND HEALTH CARE ADVERTISING

Older persons spend considerably more per capita on health care than do other adults. Many also have special dietary needs. One way the Commission assists older consumers in this regard is its program of monitoring advertising for food, drugs, and health care, and bringing law enforcement actions to stop deceptive claims.

FOOD AND FOOD SUPPLEMENT ADVERTISING

In 1991, the Commission ruled that Kraft, Inc., misrepresented the calcium content and relative calcium benefit of its Kraft "Singles" cheese slices in advertisements, and ordered Kraft not to misrepresent the content of calcium or any other nutrient in any of its cheese products. The order prohibits any such nutrient or calcium-content claim that is not substantiated by competent and reliable scientific evidence. The Commission's opinion is currently on appeal in the Federal courts.

Older consumers are especially concerned with diet as it relates to heart disease. In 1991, the Commission settled charges, by accepting a consent agreement, subject to final approval, that Bertolli U.S.A., the largest American marketer of olive oil, made false, misleading, and unsubstantiated claims about the health benefits of its olive oil products and overstated the results of a relevant scientific study. The con-

sent agreement, if finalized, among other things, would prohibit Bertolli from misrepresenting that medical science has established that eating olive oil reduces blood pressure or blood sugar. The consent agreement also would require Bertolli to have competent and reliable scientific evidence for any future claim that olive oil reduces cholesterol more than other cooking oils, reduces blood pressure or blood sugar, or is healthier for the heart than other cooking oils.

In the fall of 1991, the Commission also accepted for public comment a consent agreement with Pompeian, Inc., another olive oil manufacturer. That matter involved charges that Pompeian lacked substantiation for claims that eating vegetable oil does not lower cholesterol, that eating olive oil lowers cholesterol more than vegetable oil, and that olive oil is healthier for the heart than all vegetable oils.

In 1991, the Commission accepted for public comment a consent agreement with Pacific Rice Products, Inc., settling allegations that Pacific Rice made unsubstantiated claims regarding the health benefits of its Vita-Fiber Rice Bran cereal. According to the proposed complaint, advertisements for Vita-Fiber Rice Bran claimed that the cereal reduces cholesterol, helps reduce the risk of heart disease, will improve the ratio of HDL to LDL cholesterol in the blood, and helps reduce the serum cholesterol levels of consumers who add it to their diets. The consent agreement, if finalized, would require Pacific Rice Products, Inc. to substantiate any health-benefit claim it makes for any of its food products and would prohibit the company from misrepresenting the results of any test or study relating to such products.

Sodium intake is another significant concern to many older consumers. In 1991, the Commission charged the Stouffer Food Corp. with making deceptive claims about the sodium content of its Lean Cuisine frozen entrees. In an administrative complaint, now pending before an administrative law judge, the Commission alleged that Stouffer claimed that these entrees are low in sodium when, in many cases, the entrees were not. The Commission also charged that Stouffer's use of the term "less than 1 gram" sodium in the advertisement, without adequate disclosure that 1 gram equals 1,000 milligrams, would lead consumers to underestimate the sodium content of the entrees.

Many older consumers may desire to lose weight for health or other reasons. In the past year, the Commission actively pursued cases against companies that sell products that allegedly aid consumers in losing weight.

In 1991, the Commission continued its administrative litigation against Schering Corporation regarding the company's advertisements for the diet aid "Fibre Trim." In the summer of 1991, an FTC administrative law judge ruled that Schering advertised and promoted Fibre Trim as an effective weight-loss and weight-maintenance product without adequate substantiation for these claims. The administrative law judge also ruled, among other things, that Schering did not have substantiation for its claims that Fibre Trim provides the health benefits of a fiber-rich diet. The administrative law judge's order prohibits Schering from misrepresenting the amount and quality of fiber or other dietary components in Fibre Trim or any other product it sells. This matter is on appeal to the Commission.

In December 1990, the Commission settled charges against Allied International Corp. for allegedly false and unsubstantiated advertising claims for "Fat-Magnet" diet pills. The consent decree, approved in Federal court, permanently prohibits the company from selling or marketing any diet pills, and requires substantiation for any safety, performance, or efficacy claims for any food, drug, or device. The company is also prohibited from misrepresenting the performance, efficacy, or safety of any weight control program or service. The corporate defendants were required to pay \$750,000 as consumer redress, or disgorgement to the U.S. Treasury.

The Commission accepted for public comment a consent agreement with Nu-Day Enterprises, settling charges that Nu-Day falsely claimed that the Nu-Day diet program could change consumers' metabolism and cause weight loss without exercise. The program was advertised on a 30-minute television show which, the complaint alleged, appeared in the form of an independent consumer-news program reporting the discovery of the Nu-Day diet. The proposed complaint also charged that Nu-Day's program-length format, or "infomercial," was deceptive. The consent agreement, if finalized, among other things, would ban the allegedly false metabolism claims and prohibits unsubstantiated weight-loss or other claims about the performance of any weight-control program or service.

Many older consumers purchase services from diet clinics. In 1991, the Commission pursued 14 investigations of firms offering diet programs. These include investigations of both medically-supervised programs, i.e., very-low calorie diets involving fasting periods with a calorie intake of 420 to 800 calories per day (VLCD's), and of low-calorie programs with 1,000 to 1,200 calorie-per-day regimens (LCD's or commercial programs). Among other things, the focus of these investigations is whether var-

ious firms have made deceptive or unsubstantiated claims regarding the safety and long-term efficacy of their programs. In 1991, the Commission accepted for public comment consent agreements with three VLCD companies, Ultrafast, Medifast, and Optifast, the first settlements resulting from these investigations.

DRUG ADVERTISING

In 1991, the Commission accepted for public comment a consent agreement with St. Ives Laboratories, Inc., settling charges that it falsely and deceptively labeled and advertised its St. Ives A/Retinyl-A skin treatment cream as containing or having the same effect as Retin-A, an anti-acne medication sometimes used for reducing wrinkles. According to the proposed complaint, St. Ives misled consumers into believing that its skin treatment cream is the same as, contains, or has the same wrinkle-removing effect as the prescription drug tretinoin, which is marketed under the trade name Retin-A. The consent agreement, if finalized, among other things, would prohibit St. Ives from making a variety of representations regarding comparing the effectiveness of its skin cream or any other nonprescription skin cream to that of the prescription drug tretinoin, and from making a direct visual association between the terms "Retinyl" or "Retinol" and "A." The proposed consent agreement also would direct the company to pay \$100,000 to the U.S. Treasury.

In September 1991, a Federal district court ordered California Pacific Research and its owner to pay \$2 million plus court costs for falsely and deceptively claiming that its New General products prevent baldness and stimulate hair regrowth in those who have male pattern baldness (an inherited trait affecting up to 80 percent of the male population). In addition to the \$2 million payment, the judgment permanently bans the defendants from selling any of the New Generation products, and from representing that such products will reduce excessive hair loss or promote new hair growth. The judge's opinion noted that the FDA has determined that baldness remedy claims for nonprescription products like New Generation are either false, misleading or unsupported by scientific data.

Finally, in November 1991, the Commission charged Synchronal Corporation—one of the country's largest producers of infomercials—and others in connection with ads for a baldness cure (Omexin System for Hair), and a cellulite treatment (Anushka Bio-Response Body Contouring Program). The complaint charged that Synchronal made false and unsubstantiated claims that a scientifically proven ingredient in Omexin curtails hair loss and promotes hair growth in balding men and women. The complaint also charged that Synchronal made false and unsubstantiated claims that use of the Anushka body contouring products reduce or eliminate cellulite and cause weight loss and a substantial reduction in hips and thighs. The Commission further charged that once customers ordered these products, Synchronal unlawfully shipped bimonthly supplies without consumers' consent or knowledge, billing their credit cards for the purchases. The case is pending before an administrative law judge.

OTHER HEALTH-RELATED ADVERTISING

Colds and allergies are common problems that older consumers experience, and the Commission has pursued cases against advertisers that deceptively advertise the ability of their products to alleviate those health problems. In 1991, the Commission issued a complaint charging Viral Response Systems, Inc. (VRS) with making unsubstantiated claims that its Viralizer System, consisting of a hand-held device that blows heated air and a medicated spray into congested nasal passages, eliminates colds and relieves cold symptoms. According to the complaint, VRS claimed that the Viralizer System is "a major scientific breakthrough" that eliminates cold symptoms in 1 day or less, prevents the spread of colds, destroys the viruses responsible for colds, destroys the antibodies that cause allergic reactions, and provides long-term relief from allergy symptoms. The complaint alleged that VRS cannot substantiate any of these claims and that competent and reliable tests have not proven these claims. The matter was withdrawn recently from administrative litigation so that the Commission could consider a proposed consent agreement.

The Commission also accepted for public comment a consent agreement with Newtron Products Co., settling charges that Newtron deceptively advertised its Newtron Electrostatic Air Cleaner, a device designed to clean the air by using electricity to capture airborne pollutants. According to the proposed complaint, Newtron did not have competent and reliable scientific tests to substantiate its claims that the air cleaner removes 94 percent of fungal spores and 100 percent of pollen from the air people breathe under household living conditions. The consent agreement, if finalized, would require Newtron to have competent and reliable evidence

to substantiate any representations regarding the performance of any air cleaning product.

NONHEALTH-RELATED ACTIVITIES

FUNERAL SERVICES

The Commission's Funeral Rule, which became effective in 1984, is of particular concern to older consumers. It seeks to increase consumer access to accurate information about prices, options, and legal requirements before consumers purchase a funeral.

Since the rule's promulgation, the Commission has filed 24 enforcement actions for violations of the rule. Twenty-three of these cases resulted in court-approved consent decrees that imposed civil penalties ranging from \$10,000 to \$100,000 on funeral homes in Texas, New Mexico, Nevada, Pennsylvania, Oklahoma, Oregon, Idaho, Indiana, Illinois, Connecticut, Utah, and Washington, D.C. Some of these settlements also required consumer redress with respect to the funeral provider's charges for unauthorized services or failure to render goods or services. Seven of these 24 rule enforcement cases were brought since the beginning of FY 1991.

The Funeral Rule contains a provision requiring the Commission to re-evaluate the rule no later than 4 years after the rule's effective date to determine whether the rule should be expanded, modified, or repealed. Last year, following extensive public hearings, both the rulemaking staff and the presiding officer recommended retention of the rule plus several modifications to increase rule compliance and consumers' understanding of their rights under the rule. In November 1991, seven groups that had participated extensively throughout the proceeding presented their views to the Commission on whether the rule should be retained, modified, or repealed. The Commission is now reviewing the entire rulemaking record.

MAIL ORDER SALES

In issuing its rule relating to mail order sales, the Commission noted that those consumers with mobility problems, including older consumers, frequently order by mail. The rule requires sellers to make timely shipment of orders; give options to consumers to cancel an order and receive a prompt refund or to consent to any delay; have a reasonable basis for any promised shipping dates (the rule presumes a 30-day shipping date when no date is promised in an advertisement); and make prompt refunds. The staff of the Commission works closely with industry members and trade associations to obtain compliance with the rule, and it initiates law enforcement actions where appropriate. In the past year, the Commission has filed five mail order consent decrees in Federal district court.

The Commission is now engaged in a rulemaking proceeding to determine whether the rule should be extended to telephone order sales. In 1991, staff submitted its report recommending that the Mail Order Rule be extended to telephone sales. In the rulemaking proceeding, the American Association of Retired Persons (AARP) testified without contradiction that, according to its consumer survey data, over a given 6-month period, 27 percent of persons age 65 and older ordered products and services by telephone.

ENERGY COSTS

The cost of heating and cooling one's home can be especially burdensome to older consumers. Retired individuals spend much more time at home than working individuals, thereby having less opportunity to lower their home heating or cooling requirements during the day. In addition, the elderly may be more susceptible to hypothermia and, therefore, are often counseled to maintain a higher temperature in their homes than younger persons might comfortably tolerate. Those on fixed incomes also may face greater relative economic burdens in times of rising energy costs.

The Commission's R-value Rule assists consumers by requiring that sellers of insulation accurately disclose the "R-value," or insulating effectiveness, of such products. The rule also requires installers and new home sellers to give consumers a written disclosure of the type and R-value of the insulation installed. In 1991, to gauge the extent of compliance with the rule, the Commission received and analyzed the responses to the first round of its industrywide survey of home insulation manufacturers.

The Commission also has conducted several investigations under its Octane Rule, promulgated in 1979 pursuant to the Petroleum Marketing Practices Act. The rule establishes standard procedures for determining, certifying, and posting octane rat-

ings on gasoline pumps. In addition the Commission issued a fact sheet educating consumers on how to choose octane levels for their automobiles.

USED CAR SALES

The Used Car Rule requires that used car dealers display "Buyers Guides" on the windows of their cars to tell consumers whether the vehicle comes with a warranty or is sold "as is." These warranty disclosure requirements can be of particular benefit to older consumers, who may be less able to meet sudden, unexpected repair expenses, and who may be on fixed incomes and therefore may purchase used cars. In FY 1991, the Commission filed consent decrees against 29 used car dealers for alleged rule violations, obtaining a total of \$394,250 in civil penalties, and initiated litigation against 14 other dealers.

DOOR-TO-DOOR SALES

The Cooling-Off Rule requires that consumers be given a 3-day right to cancel certain sales that occur away from the seller's principal place of business. In 1991, the FTC charged Doro Lee Inc., which does business as Brown Hearing Aid Centers, with violating the Cooling-Off Rule in connection with the sale of hearing aids. This case is currently being litigated in Federal district court. In another matter involving another hearing aid company, Marquez Inc., the Commission approved a consent decree settling charges that the company violated the Cooling-Off Rule. The consent decree requires the company to pay a \$15,000 civil penalty, and to comply with the rule in the future.

DELIVERY OF LEGAL SERVICES

During 1991, the staff of the Commission continued its efforts to facilitate consumers' access to legal services. Removing unnecessary restrictions can benefit older consumers, whose income often exceeds limits established by government-sponsored assistance programs but may be insufficient to cover high legal fees.

In July 1991, the staff of the Commission commented to the New Mexico Supreme Court on proposed amendments to the New Mexico Code of Professional Conduct. The comment noted that the proposed amendments would generally establish more restrictive standards in the areas of attorney advertising and client solicitation. The comment suggested that several of the proposals may restrict the flow of truthful and useful information to consumers and may have the potential to impede competition or increase costs to a greater extent than necessary to achieve consumer benefits.

In March 1991, the staff of the Commission commented to the American Bar Association on the competitive effects of proposed amendments to the Association's Model Rules of Professional Conduct that would have addressed attorney operation of ancillary businesses. The comments noted that law firm diversification has the potential to provide significant benefit to consumers. The comment suggested that the specific objections to attorney operation of ancillary businesses could be addressed through narrowly tailored rules that would avoid broad limitations on the service options available to consumers.

CREDIT

In the area of consumer credit, the Commission protects older consumers by enforcing the age discrimination provisions of the Equal Credit Opportunity Act (ECOA). Although Federal law permits creditors to consider information related to age, creditors may not deny, reduce, or withdraw credit solely because an otherwise qualified applicant is over 61 years old. Retirement income must be considered in the same manner that employment income is considered in evaluating a credit application. Moreover, although credit-related insurance may be unavailable to older consumers because of their age, a creditor may use this as a reason for credit denial.

As we reported last year, the Commission in August 1990, brought age discrimination actions against a group of related finance companies doing business in two different jurisdictions. The complaints alleged that the defendants denied credit to elderly applicants whose income derived from public assistance program (Social Security), part-time employment, or retirement benefits, rather than from full-time employment. The Commission asked the courts to issue permanent injunctions and to require the payment of civil penalties. In 1991, these cases were still pending before the Federal courts.

In 1991, the Commission also settled one of its largest ECOA cases involving older consumers. The complaint in that matter charged Tower Loan with denying credit

to older applicants who did not qualify for credit life or other credit-related insurance due to their age. The complaint also alleged that Tower offered credit to elderly applicants on less favorable terms, by requiring that they obtain younger co-signers who could purchase credit insurance. In the settlement, the defendants, among other things, agreed to pay a civil penalty of \$175,000, to release from liability those co-signers obtained in violation of the ECOA, to cancel the credit insurance on such released co-signers, and to refund premiums paid for the insurance. In November 1991, the Commission also accepted a consent agreement for public comment that would settle a related administrative proceeding against Tower Loan involving Truth-in-Lending Act charges.

Older persons on reduced retirement income or with problems in their credit histories may be susceptible to sales pitches for "easy credit." Recently, there has been a proliferation of fraudulent schemes whereby firms offer automatic or easy approval for supposed general-purpose "gold cards" or VISA or Mastercard credit cards. In some instances, the "gold cards" are not general purpose credit cards as represented, and only can be used to purchase items in the seller's catalog. In other instances, the VISA and Mastercard offerings only relate to "secured" cards, i.e., cards requiring the consumer to deposit large amounts of security with the issuing bank. Sometimes, the principal aim of the sales pitch is to have the consumer call a "900" number and pay the expensive calling fee (see discussion of 900-numbers, *infra*). Having made the call and incurred the charge, the consumer finds that the sales offering is worthless.

In 1991, the commission brought four cases in Federal court against companies that allegedly misrepresented the nature and terms of the credit cards being offered. In one such case, Listworld, it was alleged that Listworld sold to telemarketers ready-made sales packages containing deceptive sales pitches for low-interest credit cards and other credit products.

INVESTMENT FRAUD

The Commission's investment fraud program is another example of a program that benefits all consumers, but especially older, retired persons. Investment frauds frequently victimize the public through false promises of large returns on "safe" investments. These frauds obviously harm all investors, but they can particularly hurt older investors, who are vulnerable to fraudulent operators and often ill-prepared to recoup the losses. Some investment fraud firms have bilked individual consumers of \$5,000 to \$10,000 or more by promising large returns for investments in art works, gold mines, gemstones, precious metals, rare coins, oil and gas leases, cellular telephone licenses, or wireless cable licenses. These firms usually employ telephone room salespersons who use high-pressure, polished sales pitches.

Last year alone, the Commission filed 11 cases in Federal district court involving such investments as rare coins, gemstones, precious metals, and investment art. In all of these cases the Commission has been able to secure initial or permanent injunctive relief. One example of a case particularly affecting older persons was Morgan Whitney, involving allegations that telemarketers deceived consumers as to the investment risk of precious metals contracts. In that case, older consumers allegedly were the principal target of the telemarketers' sales pitch. The Commission's settlement included consumer redress of over a million dollars.

In U.S. Oil and Gas, the Commission, with the help of a private receiver, obtained a redress award of over \$47 million for consumers in a telemarketing case involving the sale of oil and gas leases as investments. This was the largest redress settlement in a fraud case in the Commission's history.

OTHER TELEMARKETING SCAMS

Since 1982, the Commission has obtained injunctions against telemarketers having over \$970 million in sales. In addition to peddling investments, fraudulent telemarketers purport to offer a variety of other goods and services that may be of interest to older consumers (e.g., travel plans and home security systems).

During 1991, the Commission continued investigating travel companies engaged in telemarketing fraud, and monitoring the sales practices of companies that sell vacation or travel vouchers and certificates. As part of these efforts, the Commission obtained a final order and judgment against Vaughn Management, Inc. that included the payment of \$160,000 in consumer redress. The Commission also obtained a final order and judgment against Jet Set Travel, Inc. and its principals.

Older consumers also may be especially susceptible to fraudulent pitches for health-related products such as water purifiers. During 1991, the Commission continued its Federal court litigation against companies that allegedly misrepresented

the ability of water purifiers to remove contaminants, misrepresented prizes to be received, or failed to provide refunds to consumers as promised. In 1991, the Commission obtained a final order and judgment against Environmental Protection Systems and its principals that included the payment of \$110,000 in consumer redress. Staff of the Commission also worked with criminal law enforcement agencies in Florida and Texas to obtain convictions and prison sentences for two of the principals in the Commission's case against C & L Industries.

The Commission also is conducting an investigation of a telemarketer that sells information on living trusts in connection with estate planning, offering prizes as an incentive to purchase. Due to the nature of the product being sold, a significant number of consumers who purchase this information are older persons. Staff is investigating whether the telemarketer's claims regarding the value of the living trust information are accurate, as well as allegations that the prizes are never received and that the nature of the prizes is misrepresented.

"900" NUMBERS

The Commission continued to monitor and bring enforcement actions involving the use of "900" and other caller-paid telephone services used to sell information and products over the telephone. Calls to 900-numbers are billed at rates set by the seller of the information program, and the rates often are considerably higher than those for ordinary long-distance calls. While 900-numbers can provide valuable services, this technology has been used by some information providers to mislead consumers as to the cost of calls and the performance or nature of the goods or services the caller will receive. Some 900-number abuses, such as easy credit scams, have special importance to older consumers. By bringing cases against 900-number providers, the Commission hopes to deter these and other 900-number scams.

The Commission filed a number of 900-number cases in Federal court in 1991, and submitted extensive comments to the Federal Communications Commission regarding its proposed rules to avoid abuses in the 900-number industry.

LAND SALES

Since 1972, the Commission has issued 13 orders against land developers. The companies were charged with a variety of misrepresentations regarding the investment value of land. Many people buy investment lots to increase their retirement fund upon resale, or to serve as property on which to build retirement homes.

In a recent settlement with the Commission, Avatar Holdings, Inc. and four subsidiaries agreed to pay a \$675,000 civil penalty to settle charges that they violated a 1974 FTC order by misrepresenting the investment value and development potential of property in Arizona and Florida. A substantial number of recent purchasers of Avatar's properties were older persons.

CONSUMER EDUCATION ACTIVITIES AFFECTING OLDER CONSUMERS

The Commission, through its Office of Consumer and Business Education, is involved in preparing and disseminating a variety of consumer publications and broadcast materials. Many of the subjects are of significant interest to older consumers. Some recent consumer education activities are described below.

COMPLAINT RESOLUTION AND SHOPPING AT HOME

In 1991, the Commission worked with the National Institute for Dispute Resolution (NIDR) to produce "Road to Resolution: Settling Consumer Disputes." This booklet describes how dispute resolution programs work, the options offered by these programs, and where consumers can find such programs in their communities. The Commission, in response to requests, distributed nearly 15,000 copies of this publication in 1991.

Dispute resolution programs are being given a special emphasis by the American Association of Retired Persons (AARP). The Commission is coordinating with AARP on information and education projects in this area.

In 1991, the Commission also worked with AARP by making further distributions of "How to Write a Wrong," a booklet jointly developed by the Commission and AARP. The booklet explains how to make effective complaints about consumer problems and get results. It also contains information about two types of merchandising frequently aimed at older persons—door-to-door sales and mail order promotions. This booklet is a component of a training program developed by AARP for use in its 5,000 local offices around the country. The FTC and AARP distributed nearly 60,000

copies in 1991. More than 700,000 copies of the publication have been distributed since it has first published in 1983.

TELEMARKETING SCAMS AND OTHER FRAUDS

In 1991, the Commission developed three new publications focusing on telemarketing fraud: "Land Sales Scams," "Automatic Debit Scams," and "Fraud by Phone." These information pieces may be of significant importance to older persons, since some estimate nearly one-third of telemarketing fraud victims are age 65 and older.

"Land Sales Scams" offers tips on selecting real estate lots and explains what protections consumers have under the Interstate Land Sales Full Disclosure Act, which is administered by the Department of Housing and Urban Development (HUD). Over 15,000 English and Spanish copies were distributed by the Commission in 1991.

"Fraud by Phone" explains how fraudulent telemarketing scams work and the ways that scam artists make contact with consumers. It describes nine common frauds and offers precautions consumers can take to avoid being victimized. Over 30,000 orders for this publication were filled by the Commission in 1991.

"Automatic Debit Scams" describes a telemarketing scam in which fraudulent marketers make unauthorized withdrawals (debits) from consumers' checking accounts. The fact sheet tells consumers how to protect themselves and what to do if they are victimized. More than 25,000 copies of this publication were distributed by the Commission in 1991.

The FTC also continued to distribute existing brochures concerning various aspects of telemarketing fraud. Over the past 4 years, for example, the Commission has filled requests for more than one-half million copies of publications such as "Magazine Telephone Scams," "Telephone Investment Fraud," and "Telemarketing Travel Fraud."

The Commission also continued its efforts to provide information about other kinds of marketplace fraud that could be of special importance to older consumers. Such publications include: "Dollars For Dancing," which cautions consumers against certain contract sales used by dance studios; "Car Rental Guide," which explains car rental contract terms and suggests ways to negotiate a lower price; and "Program-length TV Commercials," television sales programs that sometimes misrepresent themselves as objective news shows. Other publications that advise consumers about products and services include: "Buying a Home Water Treatment Unit," which gives scientific purchasing information about these products; and "Lawn Service Contracts," which describes how to select a lawn service contractor who will meet work requirements and address environmental concerns. Over 200,000 orders for these five brochures have been filled over the past 3 years.

CREDIT

In 1991, the Commission, in cooperation with the National Association of Attorneys General (NAAG), produced "Credit Repair Scams" to alert consumers to fraudulent "credit repair" companies. These companies claim that, for a fee, they can erase bad credit generally and remove bankruptcy and liens from credit files. The brochure tells consumers how to spot credit repair scams, explains what information is in a credit report, and how consumers can correct mistakes themselves. Nearly 25,000 copies of this publication were distributed by the Commission in 1991. The Commission and NAAG also jointly produced a video news release (VNR) to complement the print piece.

During 1991, the FTC continued to market and distribute the following credit publications that may be especially useful to widows and other older persons who find they may have problems getting credit. "Building a Better Credit Record" explains how to understand credit reports and warns consumers against using fraudulent credit repair clinics. Since it was produced in 1988, more than 375,000 copies of the booklet have been requested. "Credit and Older Consumers," produced in 1987, explains the Equal Credit Opportunity Act, focusing on its anti-age-discrimination provisions. Since its release, more than 150,000 free copies have been distributed.

Other credit publications useful to the elderly include: "Fix Your Own Credit Problems," "Lost and Stolen Credit and ATM Cards," and "Buying and Borrowing." "Fix Your Own Credit Problems" is a how-to publication that also cautions consumers about credit repair clinics. More than 350,000 copies of this publication have been distributed in English and Spanish during the last 5 years. "Lost and Stolen Credit and ATM Cards," which discusses card-holder liability in the event of such loss, has been distributed to more than 200,000 consumers since 1987. "Buying and Borrowing," a summary of information about buying on credit, buying on layaway,

and buying by phone and mail, has been distributed to nearly 75,000 requestors over the past 5 years.

FUNERALS

During 1991, the Commission continued its print education campaign explaining key elements of the Funeral Rule. In response to individual requests, the staff of the Commission and the Consumer Information Center sent out approximately 20,000 copies of the consumer brochure last year, bringing total distribution of this publication since 1984 to nearly 400,000.

HEALTH

In 1991, the Commission worked with the AARP to produce "Hearing Aids." This fact sheet describes the two basic types of hearing loss: conductive and sensorineural. It also offers purchase suggestions for hearing aids and outlines Federal and State standards for their sale. Nearly 30,000 copies of this publication were distributed by the Commission in 1991.

The Commission and AARP also continued distribution of another AARP and FTC joint venture, "Healthy Questions," by filling requests for more than 325,000 copies in 1991. This booklet explains how to select and use the services of health care professionals, including doctors, dentists, pharmacists, and vision care specialists. Since the publication's release in 1985, nearly 1 million copies have been distributed.

In addition, the Commission produced its own consumer brochure, "Health Claims: Separating Fact from Fiction," on specific aspects of health fraud. Since its release in 1986, nearly 150,000 copies have been distributed in English and Spanish.

HOUSING

In 1991, the FTC developed "Fire Detectors" to help explain the important differences between smoke and fire detectors. The brochure briefly discusses home sprinkler systems and offers some suggestions to help reduce the chances of fire-related injuries or property loss. Over 10,000 copies of the brochure were requested in 1991.

The Commission also continued to distribute another joint AARP-FTC project, a publication entitled, "Your Home, your Choice: A Workbook for Older Persons and Their Families." The publication addresses independent and assisted living arrangements for older persons, including home health care, nursing homes, and life-care facilities. During 1991, the booklet was distributed to more than 80,000 consumers by the Commission, AARP, and the Consumer Information Center, bringing total distribution since 1985 to nearly one-half million.

In 1986, the Commission published and distributed a brochure called "Real Estate Brokers" to help familiarize consumers with ways to protect their interests when buying or selling a home. The brochure explains technical terms that are used in the industry and elaborates on matters relating to real estate contracts. Adding the requests in 1991, nearly 125,000 copies of the free brochure have been distributed.

In 1986, the Commission also released a consumer booklet, "How to Buy a Manufactured Home," prepared in cooperation with the Manufactured Housing Institute. The booklet discusses warranties and other consumer protections and explains the importance of home placement, site preparation, transportation, and installation. In 1991, nearly 15,000 copies were requested, which brings total distribution from the Commission and the Consumer Information Center to more than 110,000.

MONEY MATTERS

In late 1991, the FTC, AARP, and the National Center for Home Equity Conversation produced a joint publication entitled, "Reverse Mortgages." The brochure explains how reverse mortgages (RMs) work for consumers who are "house-rich, cash-poor." It describes the three RMs available today: FHA-insured, lender-insured, and uninsured, and it discusses the benefits and drawbacks of each plan.

In 1990, the FTC and AARP had produced "Facts About Financial Planners." This publication provides information to help consumers decide if they need a financial planner and offers guidelines for selecting a good planner. The publication also provides sample questions to ask planners during the initial interview. In 1991, the booklet was distributed to nearly 185,000 consumers by AARP, the FTC, and the Consumer Information Center.

As a companion piece to "Healthy Questions," the Commission, in cooperation with AARP, developed a consumer publication called "Money Matters." This booklet explains how to select and use the professional services of lawyers, accountants,

financial planners, estate brokers, and tax preparers. In 1991, the publication was distributed to nearly 175,000 requestors by AARP and the FTC, bringing total distribution since 1986 to approximately 900,000.

CONCLUSION

This report reviews Commission programs that may be of special significant to older consumers. It should be noted that older consumers also substantially benefit from the Commission's other general enforcement activities. In all of its work, the Commission is guided by the conviction that vigorous and honest competition is the best mechanism for satisfying consumer needs at the lowest possible cost.

ITEM 21. GENERAL ACCOUNTING OFFICE

DECEMBER 17, 1991.

DEAR MR. CHAIRMAN: This report is in response to the Committee's October 2, 1991, request for a compilation of our fiscal year 1991 products and ongoing work regarding older Americans.

GAO's work in aging reflects the continuing importance of an aging population for Federal Government programs. Today about 32 million Americans are age 65 or older. By the year 2020, that number will exceed 52 million, of which almost 7 million will be age 85 or older. Although most of the Nation's elderly citizens are healthy and independent members of society, a growing number need assistance to maintain their independence and avoid institutionalization. This changing demography will continue to challenge both government and the private sector in there 1990s and beyond.

Our work in fiscal year 1991 covered a broad range of issues, including Federal Government activities in health care, housing, income security, and social and community services. Some Federal programs, such as Social Security and Medicare, are directed primarily at the elderly. Other Federal programs target the elderly as one of several groups served, such as in the Low-Income Home Energy Assistance Block Grant or Medicaid programs. We have organized the summaries of our fiscal year 1991 reports accordingly.

In the appendixes, we describe four types of GAO activities that relate to older Americans:

• Reports on policies and programs directed primarily at older Americans (see app. I).

• Reports on policies and programs that include the elderly as one of several target groups (see app. I).

• Congressional testimonies on issues related to older Americans (see app. III).

• Ongoing work on issues related to older Americans (see app. IV).

These products, ongoing work, and the issues addressed are presented in table 1. The table shows that health and income security were the leading issues addressed among reports directed primarily at the elderly. Health was the leading issue across all types of reports and activities which either primarily affected the elderly or affected both the elderly and other groups.

TABLE 1: GAO ACTIVITIES RELATING TO THE ELDERLY IN FISCAL YEAR 1991

Issue	Type of activity			
	Reports focused on the elderly	Reports with elderly as one of several target groups	Testimony	Ongoing activities as of 9/30/91
Health	16	21	16	55
Housing	1	8	1	2
Income security	16	11	6	20
Social services	4	0	4	8
Veterans	1	7	2	29
Other	1	10	6	5
Total	39	57	35	119

Appendix I provides summaries of 39 issued reports on policies and programs directed primarily at the elderly. We include in this section reviews of health, income security, social services, and veterans' issues.

Appendix II provides summaries of 57 reports in which the elderly were one of several target groups for specific Federal policies. Many of these activities are generally financed in conjunction with services to other populations. For example, block grants fund community services or energy assistance for the elderly, as well as for other age groups; Medicaid finances nursing home care, as well as medical care for poor people of all ages.

Appendix III describes 35 testimonies given during fiscal year 1991 on subjects focused on older Americans. We testified most often on health issues. In appendix IV we have listed 119 studies related to older Americans that were ongoing as of September 30, 1991.

We are also providing information on GAO's employment of older Americans. As you are aware, our policies prohibit age discrimination (see app. V). On September 30, 1991, about 56 percent of our work force was 40 years of age or older. We continue to provide individual retirement counseling and group preretirement seminars.

As arranged with your office, we are sending copies of this report to interested congressional committees and subcommittees. Copies will also be made available to others on request.

This report was prepared under the direction on Joseph F. Delfico, Director, Income Security Issues, who may be reached at (202) 275-6193 if you have any questions. Other major contributors are listed in appendix VI.

Sincerely yours,

EDWARD A. DENSMORE,
For Lawrence H. Thompson,
Assistant Comptroller General.

APPENDIX I—FISCAL YEAR 1991 GAO REPORTS ON ISSUES PRIMARILY AFFECTING OLDER AMERICANS

During fiscal year 1991, we issued 39 reports on issues primarily affecting the elderly. Of these, 16 were on health, 1 on housing, 16 on income security, 4 on social services, 1 on veterans' issues, and 1 on other issues.

HEALTH

EMPLOYEE BENEFITS

Effect of Bankruptcy on Retiree Health Benefits (GAO/HRD-91-115, Aug. 30, 1991)

Almost half of the 40 bankrupt companies GAO surveyed terminated retiree health benefits, leaving 91,000 retirees responsible for obtaining their own health coverage. In some cases, the loss of benefits lasted for between 1 and 16 months; in others, termination was permanent. The laws intended to protect retiree health benefits in bankruptcies failed to stop companies from ending benefits because the firms either were not subject to the U.S. bankruptcy code, were legally permitted to sever benefits because they had terminated active workers' benefits as well, or had the approval of the bankruptcy court to do so. Once a company enters bankruptcy, there is little chance of securing retirees' health benefits. Therefore, GAO concludes that future efforts to increase the security of these benefits must address such issues as advance funding of benefits. Retirees from companies that self-insured were more likely to have unpaid claims for covered health services received before the plan terminated than were retirees from firms offering coverage through insurance companies or health maintenance organizations.

HEALTH CARE

Actions to Terminate Problem Hospitals From Medicare Are Inadequate (GAO/HRD-91-54, Sept. 5, 1991)

State survey agencies often spot acute care hospitals that do not comply with one or more Medicare conditions of participation. Most hospitals correct the problems identified to the satisfaction of state surveyors within the required 90 days. Yet many do not, and the Health Care Financing Administration (HCFA) rarely terminates them from Medicare. GAO believes that the penalty for noncompliance must be credible enough to make a hospital take prompt action. HCFA's termination record casts doubt on its willingness to remove any but the worst hospitals from the Medicare program. Termination for failure to correct deficiencies within 90 days may be too harsh a penalty to impose on some hospitals, however. In GAO's view,

HCFA needs a variety of options in dealing with such situations, including imposing monetary penalties, and closing beds. Termination should be used as a last resort against those few hospitals that either cannot or will not comply with Medicare requirements. Several States—in enforcing their own licensing requirements—have recognized this and supplement their termination authority with enforcement options that can be tailored to the severity of the deficiency identified.

Hospitals With Quality-of-Care Problems Need Closer Monitoring (GAO/HRD-91-40, May 9, 1991)

HCFA considers hospitals that are out of compliance with Medicare conditions of participation to be susceptible to providing poor quality care. These hospitals can be terminated from the Medicare program if they do not comply within a specified period. HCFA has been unable, however, to accurately determine whether hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are complying with Medicare conditions of participation. Further, in non-accredited hospitals, HCFA has discovered that State agency surveys are not always identifying Medicare conditions that are not being complied with. As a result, HCFA cannot be sure that quality health care is being provided to Medicare beneficiaries. Until HCFA completes development of a crosswalk that will define the relationship between Medicare conditions of participation and JCAHO standards, full access to JCAHO survey data will not greatly enhance HCFA's overall ability to evaluate the JCAHO's effectiveness in ensuring that hospitals meet Medicare requirements.

LONG-TERM CARE

Projected Needs of the Aging Baby Boom Generation (GAO/HRD-91-86, June 14, 1991)

By virtue of its numbers, the baby boom generation—about 76 million people born between 1946 and 1964—has already had a profound impact on the American education system and, in more recent years, the work force. As the baby boom generation ages, rapid growth in the numbers of elderly people who need nursing home care or care at home will increase long-term care resource requirements. This report provides information on projections of (1) the disabled elderly population and its use of long-term care services, (2) the number of home health aides required, (3) the costs of future long-term care services, and (4) the base of taxpayers or employed work force available to pay for the elderly needing care.

MEDICARE

Flawed Data Add Millions to Teaching Hospital Payments (GAO/IMTEC-91-31, June 4, 1991)

Medicare reimburses teaching hospitals over \$2 billion annually for indirect medical education costs that are thought to stem from factors like more diagnostic testing, procedures, and recordkeeping, as well as high staffing ratios associated with graduate medical education programs. The amount of the payment is determined by multiplying the amount a hospital receives for its operating costs by the number of residents per available bed and a statistically estimated factor though to represent the incremental patient care costs due to providing graduate medical education. Supplemental Medicare payments to teaching hospitals are based on inaccurate and unverifiable data, however, and are causing Medicare to pay millions more in indirect medical education costs than it should. Moreover, allowing teaching hospitals to exclude some beds used to treat sick newborns from their bed counts is inconsistent with a Federal court decision and costs the Medicare program millions each year. These weaknesses show that strong internal controls are needed. HCFA needs a valid and reliable way of determining supplemental payments so that their reasonableness can be ensured and HCFA can better control Medicare costs. Until this occurs, HCFA and the intermediaries cannot meet their responsibilities to reduce waste and abuse in the Medicare program.

Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991)

Medicare pays about one-quarter of all hospital and physician services in this country and has become the fourth-largest category of Federal expenditures, surpassed only by defense, Social Security, and interest payments on the national debt. As such, the Medicare program bears a responsibility to be a leader in health care reform, and, to a large extent, Medicare has met its responsibility in this area. De-

spite efforts to constrain costs, however, Medicare spending and beneficiary out-of-pocket expenses have risen at troubling rates. Medicare expenditures rose from about \$70 billion in 1985 to \$106 billion in 1990, while average beneficiary out-of-pocket costs rose from about \$630 to over \$1,000 for Medicare-covered services. Medicare's high cost and continued rapid growth are evidence of inadequate economic incentives for patients and providers to contain costs. Consequently, much remains to be done to translate recent payment reforms into fully functioning systems. This report identifies issues that Congress may want to examine to (1) help ensure that current Medicare reforms achieve their objectives and (2) identify additional opportunities to reduce Medicare beneficiary and program costs.

HCFA Should Improve Internal Controls Over Part B Advance Payments (GAO/HRD-91-81, Apr. 17, 1991)

During a recent review of Medicare claims-processing contractor changes, GAO discovered that the controls for advance payments that are sometimes made for physician services, medical equipment, and suppliers under part B do not ensure that the people approving these payments have clear, specific authority to do so. This report brings this weakness to the attention of the Administrator of HCFA. HCFA has not issued guidance to its regional offices or contractors on part B advances, and GAO recommends that HCFA determine whether Advance payments under part B are appropriate and, if so, develop regulations and instructions on such payments.

Information Needed to Assess Payments to Providers (GAO/HRD-91-113, Aug. 8, 1991)

Because of excessive tentative settlements made by Medicare contractors, Medicare providers may be receiving hundreds of millions of dollars each year above the amounts due them. These amounts can remain outstanding for up to 2 years before being recovered, and the Medicare trust fund could be losing about \$40 million annually in interest. Knowledge of the full extent of excessive tentative settlements and associated interest costs is limited by the incompleteness and inaccuracy of data in the HCFA information systems. GAO believes that the completeness and accuracy of information entered into these systems needs to be improved. HCFA could then analyze these data to identify problems that consistently result in excessive tentative settlements. Also, HCFA could make more informed decisions on what type of corrective action is needed and use the Hospital Cost Report Information System data to monitor tentative settlements on a broad basis. If such monitoring spotted problems, HCFA could use the detailed System Tracking for Audit and Reimbursement data for an in-depth analysis.

Millions in Disabled Beneficiary Expenditures Shifted to Employers (GAO/HRD-91-24, Apr. 10, 1991)

The Omnibus Budget Reconciliation Act of 1986 made Medicare the secondary payer for medical expenses incurred by disabled beneficiaries covered by large group health plans. This report addressed cost savings associated with this legislation and effects on employment and health insurance coverage. GAO concludes that the secondary payer provision has succeeded in shifting considerable Medicare expenditures to large group health plans without adversely affecting disabled beneficiaries or their families. In addition to suffering little adverse effect from the provisions, the disabled are safeguarded by rules proposed by HCFA in March 1990 that discourage employers from discriminating against the disabled and their families in regard to health insurance. However, future changes to employer health plans could harm disabled individuals with employee status. In proposed regulations, HCFA has identified a broad category of individuals subject to the secondary payer provision because of an active employee status. GAO is concerned that HCFA's proposed factors indicative of employee status stretch the ordinary understanding of the term "employee" and will prompt employer efforts to avoid meeting them. As a result, the number of individuals with employee status could decline by an estimated 25 percent annually.

Millions in Potential Recoveries Not Being Sought by Maryland Contractor (GAO/HRD-91-32, Jan. 25, 1991)

As part of a broader GAO effort to evaluate the adequacy of the Medicare contractor budget for claims processing and program safeguard activities, GAO discovered a situation that it believes warrants congressional attention. GAO found that Blue Cross and Blue Shield of Maryland, a Medicare claims-processing contractor, has paid at least \$8.8 million in claims for which it has identified other health insurers which may have primary payment responsibility under the Medicare second-

ary payer provisions. In this case, the contractor through its investigative efforts has identified other parties that may owe Medicare sizeable sums. However, the contractor lacks the resources to recover these amounts. GAO concludes that any additional funding of the contractor's activities to recover these payments may yield considerably more than each dollar spent for this purpose.

Need for Consistent National Payment Policy for Special Anesthesia Services (GAO/HRD-91-23, Mar. 13, 1991)

GAO looked at the extent to which "modifier units" have been used to allow extra anesthesia payments for factors like a patient's age, physical status, or unusual risk circumstances, and at the appropriateness of such payments. Before 1989, because payments for anesthesia modifiers and special monitoring procedures differed considerably among carriers, Medicare paid some anesthesiologists more than others for identical services delivered under similar circumstances. In fiscal year 1988, of the 52 Medicare carriers, 33 paid an estimated \$43 to \$72 million for anesthesia modifiers. The other carriers did not reimburse for these factors. HCFA recently discontinued separate modifier payments but required carriers to adjust conversion factors to compensate providers for the value of the discontinued modifiers. GAO's analysis of Medicare payments made by nine carriers for eight common procedures indicated that this action did not eliminate the payment inconsistencies and inequities caused by the modifier payments. Rather, HCFA's action actually perpetuated them. Also, HCFA allowed problems with special monitoring procedure payments to continue by requiring carriers to maintain prior practices. To remedy this, GAO recommends that HCFA assess the appropriateness of additional Medicare payments for anesthesia services and establish a consistent national payment policy for such services.

Payments for Clinical Laboratory Test Services Are Too High (GAO/HRD-91-59, June 10, 1991)

GAO reviewed the appropriateness of Medicare's fee schedule payments for clinical laboratory test services, considering both laboratory costs and revenues. To measure appropriateness, GAO compared laboratories' profit rates from Medicare with their overall profit rates. GAO found that profits from Medicare business substantially exceeded laboratories' overall profit rates, and GAO concludes that Medicare's fee schedules are too high. GAO recommends that the Congress cap Medicare payments for clinical laboratory test services so that Medicare's contribution to laboratories' profits does not exceed their overall profit. GAO believes that capping fees at 76 percent of the median of all fee schedules would accomplish this goal.

PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 13, 1991)

Under risk contracts, health maintenance organizations (HMOs) agree to provide all covered health care services to Medicare beneficiaries in return for a fixed payment per enrollee. While this payment system encourages HMOs to be cost efficient and to avoid unnecessary care, it may also promote inappropriate cuts in services. Peer review organizations (PROs) now assess the quality of care at HMOs. However, GAO concludes that after almost 4 years of operation, the PRO program has failed to ensure that Medicare beneficiaries enrolled in risk HMOs are receiving quality health care. GAO believes that the program's effectiveness has been impeded by a lack of strong central management from HCFA. First, HCFA has no assurance that internal quality assurance programs at most HMOs are effectively identifying and correcting quality-of-care problems. Second, the PRO external medical records review has not provided a valid assessment of the quality of care at risk HMOs, because the PROs have not had access to comprehensive HMO data from which to select their review samples. Third, HCFA has not used the PRO review results in its own HMO compliance monitoring process. While HCFA recently proposed a new PRO review methodology that it believes will correct some of these problems, GAO is concerned that it does not address the underlying data problems that have beset the PRO/HMO review program from the outset.

Variations in Payments to Anesthesiologists Linked to Anesthesia Time (GAO/HRD-91-43, Apr. 30, 1991)

Medicare costs for physician anesthesia services grew from \$757 million in fiscal year 1985 to \$1.2 billion in fiscal year 1988. In response to congressional concerns about these increased costs and the appropriateness of anesthesia times billed, GAO (1) reviewed the average anesthesia times claimed for payment for these services and compared them with average surgical times, (2) verified reported anesthesia times from patient medical records, and (3) examined the appropriateness of the an-

esthesia times Medicare recognizes for payment purposes. Unexplained variations in anesthesia time, the resulting differences in anesthesia payments, and the inability to validate anesthesia time lead GAO to conclude that the Department of Health and Human Services (HHS) should adopt an alternative to basing Medicare payment on an anesthesiologist's reported anesthesia time. GAO also believes that payment for anesthesia services should be consistent with payment for other physician services.

MEDICARE CLAIMS PROCESSING

HCFA Can Reduce the Disruptions Caused by Replacing Contractors (GAO/HRD-91-44, Apr. 4, 1991)

Beginning in December 1988, Medicare beneficiaries and health care providers in Georgia and Florida encountered serious payment delays and errors after the program changed its claims-processing contractor in Georgia and its data-processing subcontractor in Florida. This report (1) looks at the impact of these changes on beneficiaries and providers and (2) identifies actions HCFA should take to reduce the impact of any future changes.

MEDIGAP INSURANCE

Better Consumer Protection Should Result From 1990 Changes to Baucus Amendment (GAO/HRD-91-49, Mar. 5, 1991)

GAO found that Medigap sales abuses have continued. Officials in many of the 12 States GAO visited have said that abuses have declined since the implementation of the Baucus amendment, which established Federal standards for Medigap policies. When the revised standards required by the Omnibus Budget Reconciliation Act of 1990 and consumer protection provisions of the National Association of Insurance Commissioners' 1989 model regulation are fully implemented, GAO believes that they should help curb abusive marketing and sales practices. GAO found that State regulatory reviews of Medigap advertising materials vary considerably, as do State consumer education efforts related to Medigap. GAO notes that the 1988 loss ratios of about 38 percent of the companies were below the minimum standards; however, about 88 percent of premium dollars were with companies with loss ratios that met the standard.

HOUSING

TAX-EXEMPT BONDS

Retirement Center Bonds Were Risky and Benefited Moderate-Income Elderly (GAO/GGD-91-50, Mar. 29, 1991)

GAO surveyed 271 tax-exempt bonds totaling \$2.8 billion that were issued from 1980 through July 1990 on behalf of charitable organizations to finance housing for the elderly. The facilities offered a variety of living arrangements, health care, and amenities for their residents. Entrance and monthly fees supported both the specialized services and the relatively high debt payments that these highly debt-financed projects must pay. Accordingly, GAO found that 75 percent of the facilities housed residents with average incomes higher than \$15,000—making the facilities affordable only for about one-quarter of the Nation's elderly. At the end of 1989, GAO estimated that the overall default rate for these retirement center bonds was about 20 percent. In comparison, GAO estimated an overall default rate of about 1 percent for selected revenue bonds like those for industrial development projects and hospitals. GAO found that many of the defaulted projects were highly debt-financed and that the bonds' interest rates were higher than average rates paid on revenue bonds issued during the same period. This weak financial structure, combined with the inexperience of some developers and their overestimated occupancy projections, made the facilities vulnerable to default.

INCOME SECURITY

DISTRICT'S WORKFORCE

Annual Report Required by the District of Columbia Retirement Reform Act (GAO/GGD-91-71, Mar. 29, 1991)

The District of Columbia Retirement Reform Act provides for annual Federal payments to the District of Columbia Police Officers and Fire Fighters' Retirement Fund. These payments, however, are to be reduced when the disability retirement rate exceeds an established limit, a measure that was meant to encourage control of

disability retirement costs by the District government. Since the disability retirement rate reported by GAO—0.754 percent—is less than eight-tenths of one percentage point, no reduction is required in the fiscal year 1992 payment to the Fund.

EMPLOYEE STOCK OWNERSHIP PLANS

Participants' Benefits Generally Increased, but Many Plans Terminated (GAO/HRD-91-28, Dec. 10, 1990)

This report examines (1) the value of Employee Stock Ownership Plan accounts, (2) how much company stock participants are receiving, and (3) how benefits are allocated among participants. GAO found that between 1981 and 1987, participants in Employee Stock Ownership Plans fared well, with account balances generally tripling. However, because the plans are not required to diversify investments, participants relying on them for retirement benefits face increased risks. The risk involved in linking employee retirement funds to the stock performance of a single sponsoring company is highlighted by the wide range of account balances GAO discovered; some accounts were nearly worthless. Further, the higher than expected termination rates of Employee Stock Ownership Plans call into question whether current plan participants will ultimately receive a significant retirement benefit from their plan. These risks are especially significant at the many companies where the Employee Stock Ownership Plan is the only company retirement plan available to employees.

FEDERAL BENEFIT PAYMENTS

Agencies Need Death Information From Social Security to Avoid Erroneous Payments (GAO/HRD-91-3, Feb. 6, 1991)

As a result of its contacts with family members, funeral homes, and other Federal and State agencies, the Social Security Administration (SSA) maintains the most comprehensive death information in the Federal Government—if not the nation. GAO found that Federal and state agencies, which are erroneously paying out millions of dollars each month to dead beneficiaries, rarely avail themselves of SSA's comprehensive death information. Instead agencies continue to rely on voluntary reporting of deaths in order to stop payments or to adjust survivor benefits. GAO notes the existence of barriers to governmentwide use of SSA's purchased death information, including (1) State-negotiated restrictions on the use of data by other Federal agencies and (2) States' desire to be compensated by each Federal agency's use of the death information they provide. However, this State death information is a critical internal control for reducing erroneous payments in both Federal and State benefit programs, and GAO believes that it should be provided to SSA without restrictions for use by Federal and State benefit programs. GAO concludes that legislation is needed to enable SSA to more easily disclose the purchased data to other agencies. In addition, the Office of Management and Budget should require governmentwide use of SSA's comprehensive file of death information.

MAIL MANAGEMENT

Improved Social Security Mail Management Could Reduce Postage Costs (GAO/GGD-91-34, Feb. 13 1991)

This report—one in a series on how Federal agencies can improve management of their mail operations—looks at how the SSA, one of the largest civilian agency mailers, could reduce postal costs through improved mail management. GAO found that while SSA's mail managers have begun some mail cost reduction measures, more needs to be done. SSA's mailing initiatives cut fiscal year 1989 postage costs by about \$16 million. However, SSA could have further reduced mail costs by (1) using a nine-digit ZIP Code on first-class, computer-generated mail; (2) presorting first-class, computer-generated mail from large volume mailing locations; and (3) printing a barcode on outgoing mail where applicable. In addition, SSA could have reduced overpayments to the U.S. Postal Service resulting from overstating anticipated postage costs. Further, SSA lacks a multiyear mail management plan with goals and timetables for making mail management improvements.

PENSION PLANS

Fiduciary Violations in Terminated Underfunded Plans (GAO/HRD-91-87, May 13, 1991)

GAO reviewed fund abuses in pension plans for which the Pension Benefit Guaranty Corporation (PBGC) assumed responsibility. Fiduciaries' fund abuses totaling about \$9.2 million had occurred in over 25 percent, or 11, of the 40 plans GAO re-

viewed. One individual who owned businesses that sponsored three of the plans was responsible for \$7.5 million of the misused funds. The abuses mostly involved prohibited loans of plan funds to the sponsoring business or the owners using such funds for personal expenses. For some plans, PBGC was alerted to the possible misuse of funds by plan participants. In most of the other cases, PBGC staff identified the abuses when inquiring into the status of plans or reviewing the financial data. In GAO's view, PBGC's actions to recover the misused funds were reasonable, given its untimely involvement with most of the plans. PBGC is developing procedures for legislation that would allow it to fine plan administrators up to \$1,000 per day for not complying with the notification requirement. PBGC officials believe that the penalty provision will result in better compliance.

IRS Needs to Strengthen Its Enforcement Program (GAO/HRD-91-10, July 2, 1991)

Currently, about 76 million Americans count on private pension plans for retirement income. The Employee Retirement Income Security Act of 1974 (ERISA) established comprehensive standards to rid these employee benefit plans of mismanagement, fraud, and abuse, which can place plan assets at risk and threaten benefits. The Internal Revenue Service (IRS) has increased the resources it devotes to examining pension plan operations, a key element in its enforcement strategy, but IRS has been less effective than expected in identifying plans in violation of the Act. IRS's criteria for targeting plans with a high potential for violations are outdated, and most plans examined during the past 3 years were selected to train inexperienced staff, rather than because the plan was likely to have a violation. In addition, IRS has not maintained an adequate oversight program to ensure that examinations were thorough enough to detect violations. IRS intends to focus on small, underfunded plans whose sponsoring employers may have received excessive tax deductions for plan contributions. While this initiative may raise significant revenues, it shifts IRS's limited enforcement resources away from examining plans in which participants' benefits and the government's insurance program may be at risk. Further, IRS may approve design changes to many plans without a detailed review to handle an anticipated large increase in approval requests resulting from the Tax Reform Act of 1986. This could diminish IRS's ability to ensure that plan designs comply with ERISA.

Terminations, Asset Reversions, and Replacements Following Leveraged Buyouts (GAO/HRD-91-21, Mar. 4, 1991)

A leveraged buyout involves the purchase of a company with mostly borrowed funds, using the company's assets as collateral. As a result of leveraged buyouts, 345 publicly traded companies went private—at a cost of \$150 billion—between January 1982 and March 1990. Twenty percent of the defined benefit plans that GAO reviewed were terminated after the leveraged buyout. Most of these plans were overfunded, and the terminations resulted in a reversion of assets to the company. Most terminated plans were replaced, with most active participants given another defined benefit plan. GAO could not determine whether the replacement plan offered participants the same benefits as did the terminated plan. Information about the financial condition of plans that continued was limited, but when available showed that the financial condition of most plans did not deteriorate after the leveraged buyout.

PRIVATE PENSIONS

Millions of Workers Lose Federal Benefit Protection at Retirement (GAO/HRD-91-79, Apr. 25, 1991)

Insurance industry and Government data suggest that 3 to 4 million retirees and their surviving dependents receive annuities that their pension plans bought for them from life insurance companies. Even though pension plan benefits are guaranteed by Federal law, these pensioners lost this protection when they became dependent on an insurance company for retirement income. Furthermore, retirees holding these annuities may be unaware that Federal guarantees do not extend to them. Without Federal guarantees, pensioners holding insurance annuities must rely on State guarantees, which provide incomplete coverage. As a result, some pensioners could lose all or part of their pension benefits in the wake of insurance company failures. Due to limited data, GAO was unable to determine the likelihood or value of losses by annuitants. However, 170 life insurance companies have failed since 1975—40 percent of them in the last 2 years.

1986 Law Will Improve Benefit Equity in Many Small Employers' Plans (GAO/HRD-91-58, Mar. 29, 1991)

In response to concerns that women may not be receiving fair treatment under the pension system even though pension rules are gender neutral, the Congress passed the Retirement Reform Act of 1984. Before this bill became law, many participants in small employers' pension plans were treated inequitably, in GAO's view. GAO assumes that a plan is equitable if every participant earns a benefit that is the same percentage of pay per year of service; conversely, a plan is deemed inequitable if men earn more than \$1.10 in benefits as a percentage of pay per year of service for every \$1 women earn. GAO found that most defined benefit plans sponsored by small employees favored the higher-paid, who were mostly men. The Retirement Reform Act's integration changes and proposed IRS nondiscrimination rules will, GAO believes, substantially limit the extent to which a plan may favor the higher paid in the allocation of benefits. Consequently, the extent of benefit inequity should decrease in many small employers' defined benefit plans. GAO supports IRS's new rules and believes that they will result in substantial gains in benefit equity.

SOCIAL SECURITY

Analysis of a Proposal to Privatize Trust Fund Reserves (GAO/HRD-91-22, Dec. 12, 1990)

This report analyzes a proposal by a Member of Congress to create a new system of Individual Social Security Retirement Accounts. Under this proposal, part of the accumulating reserves of the Social Security Trust Fund would be returned to workers and invested in individual accounts in the private sector, where they would be held until the workers' retirement. In effect, the proposal would partially and temporarily privatize Social Security. GAO found that the proposal could be integrated with the existing progressive benefit structure and, given favorable financial market conditions, could improve retirement incomes. If implemented, the individual accounts may change the mix of public and private saving but not necessarily the magnitude of national saving. The proposal also raises many administrative difficulties and policy issues that need to be addressed before individual accounts could be considered a fully working alternative to the use of trust fund reserves.

Information About the Accuracy of Earnings Records (GAO/HRD-91-89FS, Apr. 19, 1991)

In an effort to determine the accuracy of the earnings records maintained by the SSA, GAO reviewed available studies and found that if SSA receives and processes a wage report, the chances of it recording the report to the wrong account, or in a different amount than reported, are very small. Certain studies, however, are limited in their ability to spot errors in the earnings records. In a nationwide sample of over 1,700 people who received their first retirement check in June 1985, a 1987 study found that about 6.5 percent had errors in their earnings records, although not all of these errors affected their earnings records. While GAO found no studies directly relating to the types of workers most prone to earnings record problems, an unpublished internal study of SSA's 1978 suspense file showed that in 1978, almost 20 percent of the wage reports filed by businesses involved in agricultural production and services were not credited to valid workers' Social Security accounts.

Measure of Telephone Service Accuracy Can Be Improved (GAO/HRD-91-69, Aug. 30, 1991)

This report assesses the SSA's method for measuring the accuracy of the information it provides to the public over its toll-free 800 telephone services. GAO found that SSA's method of assessing accuracy did not product consistent evaluation of the responses it provided to callers. Hence, SSA's study results were unreliable. GAO disagreed with SSA's rating of response accuracy and completeness on 35 percent of the 260 issues evaluated during 188 jointly monitored phone calls. Further, SSA reviewers inconsistently rated the responses of their teleservice representatives. The inconsistent ratings were caused by two fundamental shortcomings in SSA's "live-call" study methodology. First, SSA guidance for evaluating telephone responses was inadequate. Second, SSA did not record the telephone calls it sampled, making it hard for reviewers to make consistent and well-reasoned evaluations of conversations. In a related matter, recent legislation requires SSA to restore the public's phone access to more than 800 local SSA field offices in addition to its ongoing toll-free 800 number services. To have a comprehensive monitoring system, SSA needs to develop a methodology for measuring the accuracy of phone service to be provided by these offices.

Production Initiatives in OHA's Region V Comply With Law and Guidelines (GAO/HRD-91-36BR, Dec. 21, 1990)

Persons denied Medicare and Social Security benefits may appeal such decisions to administrative law judges (ALJ) in 132 hearing offices around the country. The Social Security Administration's Office of Hearings and Appeals (OHA) is responsible for managing these judges. GAO reviewed productivity initiatives underway in OHA's Chicago Regional Office and found that they complied with the Administrative Procedures Act and OHA guidelines. GAO also found that by including dispositions of regional chiefs and retired judges in hearing office statistics, average production figures for the Chicago region and some hearing offices were slightly overstated. However, in terms of distribution of monetary awards, the only apparent gain from the overstatement was that one hearing office receive an additional \$3,529 for awards and bonuses to support staff for which it would not have been otherwise eligible. As OHA studies and redesigns its system of productivity measures for its ALJs, it should ensure that whatever measurement system it designs fairly recognizes the work done by individuals and by offices. In the interim, GAO believes that when calculating the productivity of its hearing offices, OHA should count regional chiefs and any retired judges as resources for those hearing offices that received credit for their dispositions.

Restoration of Telephone Access to Local SSA Offices (GAO/HRD-91-76FS, Mar. 5, 1991)

In an effort to give local field offices more time for complex work and walk-in clients, the SSA began a toll-free 800 number telephone service nationwide in October 1988 that restricted the public's access to local office phone numbers. Legislation passed in 1990, however, requires SSA to publish phone numbers and addresses for affected offices and to restore the public's phone access to local offices by May 1991. This fact sheet provides information on (1) SSA's policy for directing the public to either the nationwide 800 telephone service or local field offices, (2) SSA's plans for publishing local office numbers and addresses, (3) changes in available telephone lines and equipment in affected offices since September 1989, and (4) staffing levels for these offices since September 1989.

Telephone Access to Local Field Officer (GAO/HRD-91-112, Sept. 13, 1991)

Legislation passed in 1990 requires the SSA to maintain the public's telephone access to local offices. It also requires SSA to ask phone companies to publish telephone numbers and addresses for local offices. GAO found that local SSA field offices have requested that their numbers and addresses be printed in local phone books. While SSA has maintained local office general inquiry telephone service, some offices have fewer lines and less staff available to handle telephone inquiries. SSA's local field offices have experienced reductions in both staffing and telephone equipment since September 1989, the date that the law uses as a benchmark for telephone service levels. This happened in conjunction with the agency's overall downsizing program and because it planned to convert its telephone service entirely to a national 800 telephone service. SSA interprets the law as allowing some discretion in deciding how local telephone access will be achieved. Therefore, SSA has no plans to reverse the decreases.

SOCIAL SECURITY DOWNSIZING

Significant Savings but Some Service Quality and Operational Problems (GAO/HRD-91-63, Mar. 19, 1991)

In response to an Office of Management and Budget directive, the SSA cut 17,000 staff positions. SSA completed the staff reduction on schedule and achieved cost savings for fiscal years 1985-90 of \$1.9 billion with recurring savings of \$600 million expected annually. Despite the staff cuts, SSA was able to maintain overall service at past levels, payment accuracy remained stable, and client satisfaction with the quality of SSA service remained high. These accomplishments came at a price, however. During the downsizing, employee morale plummeted, implementation of a new 800 telephone service had problems, and some processing times and pending work loads increased. In addition, staffing imbalances in certain areas caused some service deterioration. While questions have been raised about the adequacy of SSA's current staffing level, SSA lacks work-load time standards on which to base its total staffing needs. As a result, SSA's credibility was harmed in its 1992 budget request for more staff.

SOCIAL SERVICES

ADMINISTRATION ON AGING

More Federal Action Needed to Promote Service Coordination for the Elderly (GAO/HRD-91-45, Apr. 23, 1991)

Elderly Americans fear institutionalization in nursing homes, and in national polls they have expressed a desire to live in their own homes as long as possible. To maintain their independence, the elderly need an array of home and community-based services, including meal preparation, home health care, and assistance with bathing and other personal needs. About 6 million elderly need such services today, and this population is expected to grow to about 10 million by 2020. Despite its mandate to promote better coordination of services for the elderly, the Administration on Aging's efforts in the 1980's did not keep pace with growing coordination needs. Management decisions and cuts in Federal resources reduced technical assistance and information dissemination necessary to foster coordination at the State and local levels. In effect, the Administration on Aging withdrew from the "aging network" it had helped to create. As a result, its knowledge base, largely acquired from direct contact with State and local agencies, eroded and its capacity to provide assistance weakened. Improving the efficiency and quality of services provided through stronger coordination will continue to be important in the 1990's as an aging population increases the demand for home and community-based services. The Federal Government has a direct stake in strengthening coordination because it shares in the cost of financing these services. GAO believes that the Administration on Aging, through more efficient use of its resources, is in a unique position to promote coordination in the 1990's through the aging network.

ELDER ABUSE

Effectiveness of Reporting Laws and Other Factors (GAO/HRD-91-74, Apr. 24, 1991)

The term "elder abuse" refers to the abuse, the neglect, or the exploitation of people aged 60 or older. It may include physical, psychological, and sexual abuse; material or financial exploitation; and neglect or self-neglect. To help identify victims, nearly every State has passed laws on the reporting of elder abuse. Mandatory reporting laws require all people or groups of professionals, like doctors and social workers, to report cases to authorities. In contrast, people are not required to report incidences of elder abuse under voluntary reporting laws. GAO concludes that the debate over mandatory versus voluntary reporting laws will yield uncertain answers on the relative effectiveness of these laws in identifying, preventing, and treating elder abuse. State officials agree that other factors, including public awareness campaigns, interagency coordination, and in-home services and respite care, are more important than reporting laws. This suggests that improvement in elder abuse programs is more likely to result from attention to these other factors, rather than from requiring a particular kind of reporting law.

OLDER AMERICANS ACT

Promising Practice in Information and Referral Services (GAO/PEMD-91-31, Aug. 8, 1991)

The Older Americans Act of 1965 sought to improve the lives of older Americans through income, health, nutrition, employment, and long-term care programs. Promising practices in information and referral services provided under the Act include (1) providing information and referral where elderly persons live or frequently visit, (2) using automated information resources and telephone technology, (3) hiring minorities to serve diverse cultural populations, and (4) publicizing services through active outreach by mass media and presentations. All the programs GAO reviewed used multiple outreach methods, conducted some follow-up with clients or service providers, and provided training to program staff or volunteers. However, GAO's ability to evaluate success was hampered by data problems. The Administration on Aging's data collection instrument and methodology contained several flaws that raise questions about the accuracy and reliability of the national data; local data were also problematic. No formal mechanisms exist for the Administration on Aging to disseminate information about exemplary programs to other providers. Staff of these programs do sometimes exchange information through local workshops and conferences, but these methods are neither systematic nor viewed as effective by program officials.

SERVICES FOR THE ELDERLY

Longstanding Transportation Problems Need More Federal Attention (GAO/HRD-91-117, Aug. 29, 1991)

Three longstanding barriers—fragmentation of service delivery among multiple providers, confusion about program requirements, and inadequacies in data needed to manage and evaluate programs—impede effective delivery of special transportation services for the elderly in many communities. These barriers result in duplication of service in some localities at the expense of little or no service in others and higher unit costs per trip than necessary. Lower service quality could also occur for some clients. Some communities have been able to overcome special transportation barriers, but many have not. Much is known about how to reduce barriers, yet many communities are poorly informed. Without improvements in the dissemination of information on how to successfully run programs and more technical help in applying this information to local circumstances, special transportation barriers will likely remain.

VETERANS

VETERANS' BENEFITS

VA Needs to Verify Medical Expenses Claimed by Pension Beneficiaries (GAO/HRD-91-94, July 29, 1991)

In the eligibility verification report they file annually with the Department of Veterans Affairs (VA), veterans and their survivors who receive pension benefits are allowed to claim certain out-of-pocket medical expenses to offset countable income that would otherwise reduce their pension benefits. For the year ended January 26, 1990, these beneficiaries claimed over \$1.6 billion in medical expenses, resulting in income offsets of \$762 million. This meant that VA paid out an equal amount in increased pension benefits. Most of these expenses were claimed by beneficiaries in nursing homes. VA does not know whether these claimed expenses are valid, however, because it does not systematically verify or request "proof of payment" for these expenses. Because of the significant dollars involved, VA should establish procedures to validate these expenses. The need for such procedures is underscored by IRS's discovery that similar medical deductions were overstated by about 23 percent on individual tax returns.

OTHER

AGING ISSUES

Related GAO Reports and Activities in Fiscal Year 1990 (GAO/HRD-91-47, Dec. 14, 1990)

This report is a compendium of GAO's fiscal year 1990 products (reports and congressional testimony), ongoing work, and activities like speaking engagements or publications by GAO staff relating to older Americans. Income security, health care, housing, social and community services, employment and age discrimination are some of the issues addressed. This report also provides information on GAO employment of older Americans.

APPENDIX II—FISCAL YEAR 1991 GAO REPORTS ON ISSUES AFFECTING THE ELDERLY AND OTHERS

GAO issued 57 reports in fiscal year 1991 on policies and programs in which the elderly were one of several target groups. Of these, 21 were on health, 8 on housing, 11 on income security, 7 on veterans' issues, and 10 on other issues.

HEALTH

CANADIAN HEALTH INSURANCE

Lessons for the United States (GAO/HRD-91-90, June 4, 1991)

Some elements of the Canadian health care system are worthy of consideration in a reformed U.S. system because they might solve recognized problems. Canada has been more successful than the United States in controlling the growth in health care spending, even while providing health insurance to all its residents. If the universal coverage and single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for the millions of Americans who are now

uninsured. Enough would be left over to reduce, or possibly even eliminate, copayments and deductibles, if that were deemed appropriate. The Canadian system is not without flaws, however. The Canadian method of controlling hospital costs has limited the use of expensive, high-technology diagnostic and surgical procedures. As a result, waiting lists or queues—sometimes months long—have developed for some specialty surgical care services, like cardiac bypass surgery, lens implants, and magnetic resonance imaging. While the United States can learn from the Canadian model, a reformed U.S. system should also build upon the unique strengths of the existing U.S. health care structure. The continuing development of advanced medical technology; detailed management information systems; and the flexibility to incorporate alternative service delivery mechanisms, like health maintenance organizations (HMOs), are characteristics of the U.S. system that should be preserved.

COMMUNITY HEALTH CENTERS

Hospitals Can Become Centers Under Certain Conditions (GAO/HRD-91-77FS, Mar. 22, 1991)

This fact sheet provides information on whether hospitals that have closed or are at risk of closing can be converted to community health centers. HHS provides grants to nonprofit private organizations to plan, develop, and operate these centers in urban and rural areas for medically underserved people. GAO concludes that converting a hospital to a community health center is not prohibited by law or regulation. While GAO did not identify any instances in which HHS had approved grant funds to convert a hospital to a community health center, at least two centers had acquired and renovated closed hospitals in order to expand their services to needy individuals. Although HHS approved the conversions, the costs were underwritten by State and local governments and/or a loan obtained by the county.

DEFENSE HEALTH CARE

Health Promotion in DOD and the Challenges Ahead (GAO/HRD-91-75, June 4, 1991)

The DOD's health promotion program focuses on the military's major health concerns, including heart disease, cancer, and alcohol abuse. Program activities fall under six categories: (1) early identification of hypertension, (2) physical fitness, (3) alcohol and drug abuse prevention, (4) smoking cessation and prevention, (5) nutrition, and (6) stress management. The health promotion programs GAO reviewed at three military installations appeared comparable to those of the four private sector firms GAO contacted. Although studies of private sector health promotion programs have been done, the costs and benefits are hard to assess because certain common design problems limit the representativeness of the studies and the extent to which they are able to quantify and link benefits to health promotion interventions. Cost-benefit studies have not been done on DOD programs, in part because DOD has not collected cost information on its health promotion activities. DOD's health promotion program will be an important part of its efforts to reach its health goals for the year 2000, but the program needs certain enhancements, such as the development of baseline program data on the health status and behavior of its target groups, including active duty members and retirees.

EMPLOYEE BENEFITS

Improvements Needed in Enforcing Health Insurance Continuation Requirements (GAO/HRD-91-37, Dec. 18, 1990)

GAO reviewed the DOL's and the IRS's enforcement of the health insurance continuation requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This legislation requires firms employing 20 or more employees and offering a group health insurance plan to provide employees and their families the option of continued coverage in cases of job loss, death, or divorce. This report discusses (1) DOL and IRS efforts to help private individuals who bring cases of alleged noncompliance by employers to their attention, (2) procedures for investigating these allegations, and (3) enforcement history. Both IRS and DOL provide information about COBRA to those who inquire, and DOL will contact employers to help employees obtain benefits. However, if employers refuse to provide benefits, IRS cannot and DOL generally does not try to force employers to provide benefits. Further, the extent of COBRA violations is unknown. IRS's method of dealing with potential COBRA beneficiaries, in GAO's view, discourages the reporting of violations. GAO believes that DOL and IRS should do more to ensure that IRS is made aware of potential COBRA violations. The knowledge that excise taxes may be assessed for

these violations could deter such violations. Also, people referred by IRS to DOL could get help more quickly if they were given DOL's phone number along with its address.

FRAUD AND ABUSE

Stronger Controls Needed in Federal Employees Health Benefits Program (GAO/GGD-91-95, July 16, 1991)

The Congress passed the Financial Integrity Act of 1982 to reduce waste, fraud, abuse, and misappropriation of Federal program funds. Although the OPM has made some improvements in the health insurance program's internal controls, it cannot reasonably ensure that program funds are adequately protected from fraud and abuse. The Act requires Federal agencies to evaluate internal controls in the programs for which they are responsible; however, the carriers themselves are exempt from the requirements of the Act. GAO believes that OPM's Retirement and Insurance Group needs to evaluate the controls used by the carriers as part of the group's Financial Integrity Act responsibilities. OPM has found that the plans are highly vulnerable to fraud and abuse, with misappropriation of carrier funds occurring in 7 of the 25 fee-for-service plans. These cases involved embezzlement, use of plan funds to finance union or employee organization activities, improperly charging the plan for over \$1 million in expenses not incurred, and improperly charging the program \$7.2 million for Federal income taxes paid on its service charges (profit) over a 5-year period. Although the Retirement and Insurance Group has found that oversight of the carriers is too limited, the group continues to rely almost entirely on the Inspector General to perform the oversight role. In addition to the limited oversight, other control weaknesses need to be improved. OPM needs (1) to ensure that Inspector General recommendations for correcting deficiencies are implemented by the carriers and (2) to develop an aggressive programwide antifraud policy for pursuing enrollee and provider fraud. OPM also needs to use its statutory authority to penalize providers who commit fraud or program-related offenses.

HEALTH CARE

Antitrust Issues Relating to Physicians and Third-Party Payers (GAO/HRD-91-120, July 10, 1991)

This report examines (1) the effect of antitrust laws on the ability of physicians to collectively educate and discipline peers to reduce and eliminate ineffective practice patterns and inappropriate utilization and (2) antitrust issues as they relate to the adoption of practice guidelines by third-party payers. GAO concludes that U.S. antitrust laws need not unduly interfere with the responsible actions of physicians to reduce ineffective practice patterns and inappropriate utilizations or with those of payers to adopt practice guidelines. There appears to be no need at present for legislation providing antitrust immunity to physicians or payers to facilitate these activities.

HEALTH INSURANCE COVERAGE

A Profile of the Uninsured in Selected States (GAO/HRD-91-31FS, Feb. 8, 1991)

This fact sheet profiles individuals in the United States without health insurance. GAO found that in 1988 about 32 million Americans under age 65—about 15 percent of the population—lacked some form of health insurance coverage. The uninsured were concentrated most heavily among poor, young, unmarried, less educated, and minority groups. Particularly striking was the large number of working people who lacked insurance. Uninsured rates for employees in service industries—like wholesale and retail trade, real estate, and entertainment—tended to be higher than for persons in manufacturing fields—like the auto, textile, and chemical industries.

INDIAN HEALTH SERVICE

Funding Based on Historical Patterns, Not Need (GAO/HRD-91-5, Feb. 21, 1991)

The Indian Health Service now distributes funds among its 12 service delivery areas primarily on the basis of how much money each area received in past years, an approach that takes little account of the number of Indians eligible for or using services in an area, their health status, or the area's specific service needs. At a minimum, this method gives the perception of funding inequities. However, given less than full funding for the overall Indian Health Service system, GAO believes that any change in the allocation system will mean that some areas will get more funds and others less. Because the Service has met strong opposition in the past from Indian tribes facing cuts, it has had limited success in redistributing funds. In

GAO's view, the Congress may wish to consider requiring the Service to distribute its funds on the basis of other methods, such as those that give greater weight to need. In addition to discussing overall Indian Health Service funding and distribution methods, this report looks at (1) per capita funding for Indians in the Oklahoma area and (2) the effect of Service funding constraints on health services delivery in Oklahoma, with special attention to the Contract Health Services program.

MEDICAID

Alternatives for Improving the Distribution of Funds (GAO/HRD-91-66FS, May 20, 1991)

GAO reported on the fairness of the formula used to distribute Medicaid funds to the States. GAO suggested replacing the existing per capita income factor with two other factors: (1) total taxable resources and (2) people in poverty. To illustrate their effect, GAO offered one alternative, designed to be budget neutral, that lowered the minimum Federal reimbursement rate from its current value of 50 to 40 percent. This would reduce reimbursements to those States with high incomes and low poverty rates. In this fact sheet, GAO describes that alternative and several others meant to improve the distribution of Medicaid funds. Each alternative uses the two factors replacing per capita income, but differs in the size of the minimum Federal reimbursement rate and the level of Federal funding.

HCFA Needs Authority to Enforce Third-Party Requirements on States (GAO/HRD-91-60, Apr. 11, 1991)

States are supposed to resort to Medicaid payment for health care only after a recipient's other health care resources have been exhausted. The Health Care Financing Administration (HCFA), however, has identified significant State noncompliance with Federal third-party requirements. Although HCFA has not estimated Medicaid program losses resulting from this noncompliance, GAO found more than \$175 million in backlogged claims in two States for which third parties may have some liability. The Omnibus Budget Reconciliation Act of 1985, while imposing additional third-party requirements on States, has severely limited HCFA's enforcement authority. As a practical matter, HCFA's authority to enforce third-party requirements with financial penalties is almost nonexistent. To encourage States to comply with these requirements and, when they do not, ensure that the Federal Government does not contribute to Medicaid payments, the Congress should broaden HCFA's authority to impose financial penalties.

Legislation Needed to Improve Collections from Private Insurers (GAO/HRD-91-25, Nov. 30, 1990)

As a public assistance program, Medicaid was expected to pay for health care only after Medicaid recipients had used all their other health care resources. GAO found that two major problems hinder States from collecting from private insurers for recipients' covered health care costs. First, States cannot prohibit some out-of-State insurers from trying to avoid paying State Medicaid agencies for such costs. States now lack jurisdiction over insurers that operate only incidentally in the State. Second, States' limited authority over plans covered under the Employee Retirement Income Security Act of 1974 (ERISA) does not allow them to prohibit these plans from trying to avoid payments for recipients' covered costs. Further, many States have not exercised that authority they do have to mandate that no ERISA plan include any contract provision that might limit or exclude payments for Medicaid recipients' health care costs. While State officials found it hard to pinpoint losses resulting from their payment systems, examples of state Medicaid losses obtained by GAO suggest that the problem may be substantial—perhaps millions of dollars in losses each year—and growing. To minimize future losses, Federal legislation is needed to clarify Medicaid's role as a payer of last resort and to enhance the ability of States to collect from out-of-state insurers and ERISA plans.

Millions of Dollars Not Recovered From Michigan Blue Cross/Blue Shield (GAO/HRD-91-12, Nov. 30, 1990)

Over the past 18 years, the Michigan Medicaid agency has had serious difficulties in recovering payments made for Medicaid recipients insured by Blue Cross/Blue Shield. GAO found that Michigan has not fully used its authority or taken all available action to enforce Blue Cross/Blue Shield compliance with Medicaid's third-party recovery provisions. Ineffective State management, coupled with lack of leadership by (HCFA), has allowed millions of dollars to go unrecovered from Blue Cross/Blue Shield. A big part of the problem has been that insurers can profit financially by setting up legal or administrative barriers to delay or postpone pay-

ments to the State. As a result, GAO recommends that the Medicaid statute be changed to allow assessment of double damages on insurers that do not pay when they should. GAO is also evaluating more broadly the options available to the Federal Government when a State like Michigan has not met its responsibilities to recover Medicaid costs. Until changes are made in the Medicaid recovery system, Michigan and the Federal Government will continue to pay the bill for claims for which Blue Cross/Blue Shield is liable.

MEDICAID EXPANSIONS

Coverage Improves but State Fiscal Problems Jeopardize Continued Progress (GAO/HRD-91-78, June 25, 1991)

Since 1984, the Congress has made several modifications to the Medicaid program aimed at expanding eligibility and improving services. These measures helped reverse the effects of earlier cutbacks, which had severely reduced the access of low-income families to medical services. Gains are most evident in States whose coverage in 1984 was relatively limited. The changes have reduced disparities among States in access to Medicaid services for pregnant women and children. While States' costs for these gains were relatively modest—\$900 per capita for low-income women and children annually versus an average of \$2,400 for recipients overall—the Medicaid program as a whole contributed to State fiscal stress during this period. It is the second largest program in most States and is generally the fastest growing. Judging by the last 6 years, it appears that future expansion of Medicaid access could be jeopardized by the combined effects of budget shortfalls recession-related increases in levels of need, and more costly Medicaid mandates.

MEDICAL ADP SYSTEMS

Automated Medical Records Hold Promise to Improve Patient Care (GAO/IMTEC-91-5, Jan. 22, 1991)

The United States spends more than half a trillion dollars each year on health care, yet the use of automation in the health care industry lags behind that of other industries. GAO found that automated medical records may greatly improve the management of patient care. Such records are far more accessible, complete, and accurate than paper records and could potentially increase staff productivity and decrease operating costs. Several factors have, however, impeded progress in health care automation, including costliness, lack of fully developed technology, potential misuse of automated information, and user resistance to automated systems. Further, the lack of standardization in data collection and processing limits the usefulness of this information for research. Automated records also raise security, privacy, and legal questions. GAO believes that the health care community needs to find solutions to the problems associated with automating medical records. In GAO's view, the issue is less whether computers can support medical practice than how to bring about the development and use of the technology to do so.

MEDICAL MALPRACTICE

Data on Claims Needed to Evaluate Health Centers' Insurance Alternatives (GAO/HRD-91-93, May 2, 1991)

To help provide health care to vulnerable populations—including poor pregnant women, the homeless, migrant workers, and HIV-infected people—the Bureau of Health Care Delivery and Assistance awards grants to public or nonprofit facilities. About 10 percent of the Federal funds is spent on malpractice insurance. If recipient facilities could reduce their malpractice insurance costs, they could provide health care to more people without increasing Federal grant expenditures. To help the Congress consider alternative ways of providing insurance for these facilities, GAO identified elements needed to assess alternatives, which may include (1) the Federal Government assuming liability under the Federal Tort Claims Act, (2) establishing a risk-retention group to self-insure the centers and (3) purchasing commercial insurance through a nationally formed risk-purchasing group. Historical claims experience is critical to assessing the alternatives, but claims data are too limited or dated to form an adequate basis for assessment.

Few Claims Resolved Through Michigan's Voluntary Arbitration Program (GAO/HRD-91-38, Dec. 27, 1990)

The current ways of resolving medical malpractice claims in this country are neither efficient nor equitable. Claims take a long time to be resolved, awards and settlement are unpredictable, and legal costs are steep. Concern about the existing

system has inspired alternative proposals for claims resolution, including fault-based and no-fault-based approaches. This report looks at one of the fault-based alternatives—the Michigan Medical Malpractice Arbitration Program. GAO assessed (1) the extent of hospital, health care provider, and patient participation under the Michigan plan; (2) the arbitration alternative's effect on medical malpractice claims resolution; and (3) whether arbitration contributed to reducing medical malpractice insurance costs. GAO's conclusions about the program are limited because program participation has been low. GAO does not foresee significant increases in program participation because of the voluntary nature of the program and because of the lack of incentives for patient participation.

OFF-LABEL DRUGS

Reimbursement Policies Constrain Physicians in Their Choice of Cancer Therapies (GAO/PEMD-91-14, Sept. 27, 1991)

Physicians argue that the treatment of cancer patients is being compromised by restrictions on health care. Specifically, oncologists report that health insurers are denying reimbursements for some drugs used "off label" (that is, using drugs approved for one type of cancer to treat other types). GAO found that off-label use of anticancer drugs is widespread; one-third of all drugs given to cancer patients were off-label, and more than half of the oncologists GAO surveyed reported reimbursement problems for the use of drugs off-label, with most indicating that problems were getting worse. Respondents also reported that reimbursement policies and the costs of certain drugs have made them alter their preferred treatments. Most important—because of the high prevalence of the diseases—is GAO's finding that the treatments for lung and colon cancers were among those most influenced by reimbursement policies. Some 62 percent of GAO's respondents reported admitting patients to the hospital solely to circumvent restrictions imposed by reimbursement policies. They are doing so because drug reimbursement policies are generally less restrictive for inpatient care.

PRIVATE HEALTH INSURANCE

Problems Caused by a Segmented Market (GAO/HRD-91-114, July 2, 1991)

GAO discusses the problems of availability and affordability of private health insurance, particularly for small businesses. GAO also looks at some reform attempts proposed by interested organizations and discusses some of their limitations.

RURAL HOSPITALS

Federal Effort Should Target Areas Where Closures Would Threaten Access to Care (GAO/HRD-91-41, Feb. 15, 1991)

Between 1980 and 1988, 200 rural hospitals closed—about one-half of the total number of hospitals that closed over that period. GAO examined the factors that contribute to the risk of closure and assessed the impact rural hospital closures have on access to medical care, health care costs, and local economies. GAO found that the factors associated with a high risk of closure did not include rural location. Factors did include small size, low occupancy rate, weak local economy, and competition from other hospitals; a higher percentage of rural hospitals suffer from some combination of these contributing factors. Most rural hospital closures did not significantly reduce access to care, but in some areas closures did appear to worsen access, especially for Medicaid recipients and the uninsured. GAO recommends that Federal and State programs designed to provide relief for hospitals undertake to identify those hospitals at risk of closure and assess the impact of such closure on access to care. Programs could then target funding to communities that would be most adversely affected.

SUBSTANCE ABUSE TREATMENT

Medicaid Allows Some Services but Generally Limits Coverage (GAO/HRD-91-92, June 13, 1991)

States are shouldering most of the funding burden for substance abuse treatment services, with the Federal Government assisting through block grants. The Federal Government also reimburses States for treatment of some substance abusers through the Federal-State Medicaid program. The Congress has been concerned about the HCFA's lack of a national policy on the use of Medicaid funds for substance abuse and about HCFA, in the absence of specific guidance in law or regulation, giving States differing interpretations on what substance abuse treatment services Medicaid would reimburse. This report examines Federal guidance to the States

on Medicaid coverage of substance abuse treatment services, the types of Medicaid services available in States, the level of Federal and State spending, and barriers that may exist to obtaining treatment reimbursement by Medicaid.

U.S. HEALTH CARE SPENDING

Trends, Contributing Factors, and Proposals for Reform (GAO/HRD-91-102, June 10, 1991)

GAO discusses U.S. health spending trends; their effects on business, government, and individuals; factors contributing to rising expenditures; and a comprehensive approach to reform.

HOUSING

ASSISTED HOUSING

Utility Allowances Often Fall Short of Actual Utility Expenses (GAO/RCED-91-40A and GAO/RCED-91-40B, Mar. 26, 1991)

While over 3 million lower income households now receive rental housing assistance through HUD's public housing and section 8 certificate programs, concerns have arisen that many of these households are not receiving adequate allowances to pay their utility bills. The first volume of this report examines how utility allowances are provided to households and the extent to which the allowances cover utility costs. It also discusses benefits and drawbacks of two alternatives for ensuring that a greater proportion of assisted households pay 30 percent of their adjusted income for rent and utilities. The second volume presents detailed results on utility allowance practices from a nationwide survey of public housing agencies. It also contains the results of GAO's review of household rent payments, utility allowances, and utility costs for an estimated 9,500 households at six housing agencies.

COMMUNITY DEVELOPMENT

Oversight of Block Grant Monitoring Needs Improvement (GAO/RCED-91-23, Jan. 30, 1991)

Local governments rely on the Community Development Block Grant program to help meet locally defined community development needs, including the creation of decent housing and the expansion of economic opportunities. However, the Office of Inspector General found that many problems plagued the administration of grantees' programs. GAO reviewed three field offices (Baltimore, MD; Columbus, OH; and Detroit, MI) to determine how they monitored entitlement grantees of Community Development Block Grants. GAO found that weaknesses in HUD's guidance for monitoring entitlement grantees may have contributed to inadequate supervisory and evidentiary control practices. Without adequate supervisory and evidentiary controls over its monitoring program, HUD cannot ensure that management problems are detected or that staff do not duplicate previous work. In addition, without using information found in Office of Inspector General reports when planning their monitoring, field offices may not be using their limited resources most effectively.

D.C. GOVERNMENT

Information on the Homeless Family Program (GAO/GGD-91-108, Aug. 22, 1991)

While the District of Columbia has been providing housing to homeless families since the mid-1960's, enactment of the D.C. Right to Overnight Shelter Initiative of 1984 gave every homeless person in the District the right to overnight shelter. As a result, the number of homeless families assisted has increased more than 300 percent from fiscal years 1984 through 1990. This report addresses five issues concerning the operation of the District's homeless family program: (1) What approaches has the District used to acquire its apartment-style shelter housing? (2) What is the District paying for contract shelter and support services? (3) How does the District monitor contractor performance? (4) How many once-homeless families have located permanent housing? (5) How many families who left a shelter have returned to the program?

HOMELESSNESS

Access to McKinney Act Programs Improved but Better Oversight Needed (GAO/RCED-91-29, Dec. 28, 1990)

GAO found that HUD, and HHS, and the Departments of Education and Labor (DOL) have eased barriers that assistance providers and others claimed hindered

their efforts to help the homeless through McKinney Act program funds. These barriers included requirements for matching funds, environmental reviews, and time limits for program expenditures. While all Federal agencies have made it easier to obtain McKinney Act funds, monitoring efforts vary. GAO believes that without adequate monitoring, there is a greater likelihood of misused funds and inefficient programs. Further, the lack of (1) Federal guidance to assistance providers on the type of data they should be collecting for evaluation and (2) program effectiveness evaluations have hindered the Government's knowledge of whether McKinney Act programs are working. Although agency officials believe that the reduction in barriers will make it easier for grantees to obtain McKinney Act funds, they are concerned about how slowly some grantees are spending the funds. As a result, Federal agency officials have changed their program regulations, issued guidance, and proposed legislative changes to ensure that program funds are spent in a more timely manner.

Action Needed to Make Federal Surplus Property Program More Effective (GAO/RCED-91-33, Oct. 9, 1990)

GAO found that although there has been progress in making surplus Federal property available for use by the homeless under title V of the McKinney Act, problems remain that hinder the effective implementation of title V. Specifically, properties are being listed in the Federal Register as suitable for homeless use before screening for federal need is completed. As a result, assistance providers are misled and may be applying for properties that are unavailable. In addition, many assistance providers are dissatisfied because they lack easy access to the Federal Register. In response, the GSA and HUD have developed additional ways of publicizing Federal properties, including sending notices directly to interested assistance providers. The McKinney Act authorizes only the leasing of Federal properties and not transfers of property titles and donations. As a result, some assistance providers say that they cannot afford to renovate these properties or obtain loans to do so because leased property cannot be used as loan collateral. GAO believes that Federal leases for facilities for the homeless may expose the Government to liability. Also, local jurisdictions may seek compensation for additional costs associated with nongovernment use, such as emergency services for shelter residents. Changes in the leases could minimize these potential costs.

Federal Personal Property Donations Provide Limited Benefit to the Homeless (GAO/HRD-91-108, July 15, 1991)

The Federal Surplus Property Donation Program disposes of property no longer needed by Federal agencies; items range from heavy equipment, like planes, ships, cars, and construction equipment, to more common domestic items, like clothing, kitchen equipment, hardware, furniture, and office equipment. Property not claimed by groups, such as the Boy Scouts or the Red Cross, is then made available to State agencies, which can distribute it to public and nonprofit private organizations, including homelessness assistance providers. Overall, GAO found that the program is not a significant source of aid to the homeless. In fiscal year 1990, according to GSA estimates, only about one-twentieth as many providers obtained property directly from State agencies for surplus property as received assistance through the single largest McKinney Act program. The dollar value of the donations these providers have received since 1987 has also been limited. The donation program is limited in its potential to help the homeless because of the types of items available for donation, the resources required for providers to obtain donated items, the priority assigned to providers in the distribution process, and an impractical reporting requirement. Neither the types of property available for donation nor the resources required for homelessness assistance providers to participate could be altered without changing the overall purpose and focus of the donation program. Providers could, however, be allowed to select surplus items earlier in the disposal process, and restrictions on the use of donated property could be modified to simplify providers' administrative tasks.

McKinney Act Programs and Funding Through Fiscal Year 1990 (GAO/RCED-91-126, May 1, 1991)

The McKinney Act's homeless assistance programs provide the homeless with emergency food and shelter, transitional and permanent housing, primary health care services, mental health care, alcohol and drug abuse treatment, education, and job training. This report provides a legislative history of the Act, describes each program established pursuant to the Act, and lists the amount of money provided under each program by state for fiscal year 1990. The Congress appropriated about \$600 million for 18 direct assistance programs for the homeless and the Interagency

Council on the Homeless. Of the 18 programs, 6 provided funds through a formula, or block-grant-type process, and 12 used a competitive process. The single largest funded program for 1990 was the Federal Emergency Management Agency's Emergency Food and Shelter Program, which received around \$496 million. The Congress appropriated about \$655 million for 15 existing programs and 5 new ones for fiscal year 1991 and the Interagency Council on the Homeless.

HOUSING FOR THE ELDERLY

HUD Policy Decisions Delay Section 202 Construction Costs (GAO/RCED-91-4, 1991)

Under the section 202 program, nonprofit organizations receive direct loans for building or rehabilitating rental housing for the elderly and handicapped, primarily those of lower income. Over the past 9 years the time required to process a section 202 project has increased. In 1988, HUD had a 3-year backlog of projects for which construction had not yet begun. As a result, housing assistance to many low-income elderly and handicapped people has been delayed. GAO identified three main reasons for processing delays: (1) HUD has indirectly restricted funds available to finance 202 projects by establishing fair market rents that are too low in some cases and do not reflect the cost of construction; (2) HUD offices are inconsistent in their cost containment reviews and often change project plans in an effort to lower costs to limits supportable by fair market rents; and (3) HUD's field offices vary in their administration of the program, with some offices having developed effective processing procedures while others have not. This report contains recommendations to the Secretary of HUD for ensuring the timely completion of section 202 projects.

INCOME SECURITY

COMPUTER MATCHING ACT

Many States Did Not Comply With 30-Day Notice or Data-Verification Provisions (GAO/HRD-91-39, Feb. 8, 1991)

To improve payment integrity and to reduce erroneous payments in the face of mounting budget deficits, the Congress passed legislation in 1984 requiring each State to determine recipients' eligibility for Aid to Families With Dependent Children (AFDC), Food Stamps, Medicaid, and other programs by computer-matching Federal income tax data as well as other Federal and State source data. States were required to give recipients at least 10 days notice before reducing or cutting off benefits. The Computer Matching and Privacy Protection Act of 1988 expanded the data-verification and advance notice provisions by directing States to (1) independently verify all federally furnished data, including that provided by the SSA, used in a State computer matching program and (2) give people at least 30 days notice before cutting any benefits. A majority of the States told GAO that they had implemented the 30-day notice and data-verification provisions, although some States said that these provisions would be costly and expressed hope that the Congress would amend the provisions. As of June 1990, over half the States had implemented the 30-day provision; the rest said that they were planning to do so in the near future. GAO found that while most States used SSA benefit data in their computer matching programs, nearly half did not verify this information. About 22 percent of the States said that the Act's provisions conflicted with State laws or regulations, which often required a 10-day notice period. Although 26 States provided cost estimates for implementing the 30-day notice provision, GAO found these estimates to be unreliable.

DEBT MANAGEMENT

More Aggressive Actions Needed to Reduce Billions in Overpayments (GAO/HRD-91-46, July 9, 1991)

This report assesses the effectiveness of SSA's efforts to improve its collections of overpayments and provides information on the debt management practices of several other agencies. From 1986-89, SSA's overpayments collections remained a constant 28 percent of outstanding debt. GAO concluded that SSA made little progress in increasing the percentage of debt collected because it lacked an organizational focus and emphasis on debt management, had insufficient information to control and account for the more than \$2 billion in overpayments, did not adhere to debt collection policies, and had been legally restricted from using certain collection methods that have been successfully used by other agencies. GAO made a number of recommendations to correct these problems.

FINANCIAL AUDIT

Food and Nutrition Service's Financial Statements for Fiscal Years 1988 and 1987 (GAO/AFMD-91-3, Dec. 21, 1990)

This report presents the results of GAO's financial audit of the Agriculture Department's Food and Nutrition Service (FNS) for fiscal years 1988 and 1987. GAO found that, due to weak internal controls, FNS is not adequately monitoring States' control over food coupons, which increases the chance of theft or abuse of coupons. Also, FNS does not produce reliable financial statements; its financial staff did not apply generally accepted accounting principles for the years examined, leading to significant errors in the agency's financial statements. GAO makes several recommendations aimed at correcting these weaknesses.

LOW-INCOME HOME ENERGY ASSISTANCE

A Program Overview (GAO/HRD-91-1BR, Oct. 23, 1990)

The Low-Income Home Energy Assistance Program (LIHEAP) provides eligible households with assistance for home energy costs. Assistance is available to (1) help families pay heating and cooling costs, (2) prevent energy cutoff in crisis situations, and (3) help families make their homes more efficient. This report provides background information on the program in preparation for hearings on the program's reauthorization in 1990.

HHS Has Not Assured State Compliance With Administrative Cost Restrictions (GAO/HRD-91-15, Nov. 13, 1990)

The LIHEAP provides eligible households with assistance for home heating and cooling, home weatherization, and home energy crises. The HHS distributes funds to States, which are responsible for administering the program. The legislation authorizing the program requested that States not use more than 10 percent of LIHEAP funds for administrative and planning costs. GAO reviewed the program in Georgia, and found that two local agencies administering LIHEAP on behalf of the States were planning to use other Federal funds to supplement the available LIHEAP funds to meet administrative and planning costs. This practice could have resulted in more than 10 percent of administrative costs being paid with Federal funds, which the law prohibits. Georgia State officials were advised of this possibility and said that the State would take steps to prevent this from happening in 1990 and future years. GAO also found that HHS does not now monitor for possible noncompliance, and recommended actions the HHS Secretary could take to ensure that administrative costs in excess of 10 percent are paid with non-Federal funds, which the law allows.

Observations on HHS's Administration of the Program (GAO/HRD-91-119FS, Sept. 30, 1991)

The most prominent of several Federal programs that provide energy assistance for the poor, the LIHEAP was created in 1981. In effect, a series of one-time Federal categorical crisis assistance program aimed at supplementing the incomes of recipients to meet their energy expenses was converted into a State-run Federal block grant program. The Office of Energy Assistance (OEA) within the HHS manages LIHEAP. To ensure that Federal legal and regulatory requirements are met, OEA reviews the annual requests that States, territories, and Indian tribes submit for LIHEAP funds and conducts compliance reviews. Most grantees are reviewed for compliance about once every 5 years. While about half of the reviews are conducted on-site, the others are done in Washington, D.C., and are based on information supplied to OEA by the grantees. Noncompliance cases often take years to fully resolve, although OEA has made some headway recently in reducing the backlog.

States Cushioned Funding Cuts but Also Scaled Back Program Benefits (GAO/HRD-91-13, Jan. 24, 1991)

The LIHEAP provides eligible households with assistance for home energy costs. Assistance is available to (1) help families with cooling costs, (2) prevent energy cutoffs in crisis situations, and (3) help families make their homes more energy efficient. GAO found that between fiscal years 1986 and 1989, the States—while offsetting about one-fourth of the cuts in Federal funding for the program, mainly with oil overcharge funds resulting from legal settlements with major oil producers—scaled back energy assistance benefits. In addition, most States served fewer households, although 43 percent attributed the decrease to factors other than Federal funding cuts, such as improved economic conditions that reduced the need for assistance. States generally complied with key program requirements by assuring the

HHS that they were (1) doing outreach activities, especially for the elderly and handicapped, and (2) targeting benefits to households most in need. Also, the four States GAO visited had incorporated fiscal controls to prevent erroneous payments. GAO found that in nearly all States, other Government and private sector programs provide home energy assistance to low-income households. In fiscal year 1989, this assistance amounted to about \$200 million.

SOCIAL SECURITY

District Managers' Views on Outreach for Supplemental Security Income Program (GAO/HRD-91-19FS, Oct. 30, 1990)

This fact sheet presents the results of GAO's telephone survey on the outreach activities for the Supplemental Security Income program carried out by field offices of the SSA. Outreach is done because many nonparticipants who may be eligible for Supplemental Security Income may be unaware of the program or of their eligibility for benefits.

SOCIAL SECURITY DISABILITY

Action Needed to Improve Use of Medical Experts at Hearings (GAO/HRD-91-68, May 20, 1991)

When individuals are denied Social Security disability benefits, they may appeal to administrative law judges (ALJ), who may seek out medical expert testimony in deciding on the validity of a claim. The SSA's Office of Hearings and Appeals (OHA) relies on a fee schedule to determine payments for these medical experts, who are to be selected to testify on a rotational basis. GAO found that when purchasing medical expert testimony, OHA has not ensured compliance with either its rotation policy or Federal procurement policy. Many hearing offices in the Chicago region use specific medical experts repeatedly rather than rotating among a number of individuals with the same medical specialty. In addition, some hearing offices may have relied unnecessarily on one medical expert for referrals in high-demand medical specialties. Frequent use of individual medical experts occurred nationwide for this same reason. The high use of specific medical experts has resulted from (1) inadequate hearing office controls over the selection process, (2) inadequate regional office oversight of medical expert use by hearing offices, and (3) insufficient recruitment efforts. Repeated use of medical experts has led to questions about the impartiality and independence of the system, and GAO believes that OHA needs to strengthen its oversight and procedures.

WELFARE BENEFITS

States Need Social Security's Death Data To Avoid Payment Error of Fraud (GAO/HRD-91-73, Apr. 2, 1991)

Each year, the Federal Government spends billions of dollars on State-administered welfare programs like Aid to Families With Dependent Children, Food Stamps, and Medicaid; States spend billions more in welfare benefits through their State-funded general assistance programs. While payments should promptly cease once a beneficiary dies, a GAO review in the mid-Atlantic region—Maryland, Pennsylvania, and the District of Columbia—discovered nearly 3,000 cases during a 2-year period in which benefit payments continued for up to 2 years or more after the beneficiaries had died. GAO believes that erroneous welfare payments and welfare fraud could be reduced or avoided by having the SSA routinely provide States with death information contained in its files. With minimal investment, SSA could modify its Social Security number verification system to provide States with available death information.

WORKERS AT RISK

Increased Numbers in Contingent Employment Lack Insurance, Other Benefits (GAO/HRD-91-56, Mar. 8, 1991)

This report examines the "contingent" work force—nontraditional work arrangements like part-time, temporary, and contract employment. GAO found that a large segment of the work force—estimated at about 32 million—have jobs that no longer fit the description of traditional, full-time permanent employment; this segment of the work force is expected to grow in coming years. Many of these workers, particularly those who head families, lack the economic protections enjoyed by their full-time counterparts. Part-time workers generally receive lower pay and fewer benefits than do workers in comparable full-time jobs. For example, one in five part-time workers lacks health insurance, and only 10 percent of part-time workers are in-

cluded in their employers' pension plans. Nontraditional workers often do not qualify for federal/state worker and income security protection programs. Accordingly, many of these individuals, especially those supporting families, may slip more easily into poverty. The absence of data on contingent workers has sharply limited the analysis that can be done of the problems these workers may face and the related policy consequences.

VETERANS

FINANCIAL AUDIT

Department of Veterans Affairs Financial Statements for Fiscal Years 1989 and 1988 (GAO/AFMD-91-6, Nov. 14, 1990)

This report presents the results of GAO's financial audit of the fiscal years 1989 and 1988. In GAO's opinion, except for property and equipment, VA's financial statements are fairly stated in accordance with generally accepted accounting principles. The property and equipment accounts shown in the financial statement are inaccurate primarily because of missing or undocumented values of the assets and the inconsistent adherence to capitalization and depreciation policies by VA's field personnel. In addition to the audit reports, GAO discusses and analyzes VA's financial position and operations, including VA health care costs and veterans' benefits costs. GAO also includes a statement analyzing VA's appropriation activity and a summary of VA's self-assessment of internal controls under the Federal Managements' Financial Integrity Act. VA's self-assessment identifies eight areas where its major accounting systems fail to conform with accounting principles and standards for Government agencies. These areas include weaknesses in controls over property and equipment accounts, security controls at automated data processing centers, and the inability to adequately control funds and effectively detect duplicate payments for the loan guaranty program. GAO believes that a financial statement that analyzes appropriation activity is a desirable addition to the standard set of financial statements, providing fuller reporting of the relationship between accrual-based statements and the status of appropriations used. GAO also believes that a summary of an agency's Financial Integrity Act report should be part of an agency's annual report and should be eventually included within the scope of the independent auditor's worked and report.

MEDICAID

Changes in Drug Prices Paid by VA and DOD Since Enactment of Rebate Provisions (GAO/HRD-91-139, Sept. 18, 1991)

In 1990, rapid increases in Medicaid prescription drug costs led the Congress to significantly change how Medicaid programs pay for outpatient prescription drugs. Drug manufacturers are now required to give rebates to State Medicaid programs on the basis of the discounts offered to large purchasers. Reports that drug manufacturers were raising prices charged to the Departments of Veterans Affairs and Defense raised congressional concerns about the impact of the legislation on Federal agencies' costs. This report focuses on how the prescription drug prices paid by the two departments have changed and what effect the changes have had on costs.

VA HEALTH CARE

Actions in Response to VA's 1989 Mortality Study (GAO/HRD-91-26, Nov. 27, 1991)

GAO reviewed follow-up actions taken by the VA to address quality-of-care problems documented in a June 1989 report about VA medical centers. In that report, VA said that 44 of its 172 medical centers had higher-than-normal mortality rates in 1986, and that "likely" quality of care problems were found in 90 cases in which deaths occurred. GAO found that most of the actions VA planned to take to assess the significance of the mortality study findings had been completed. VA is still analyzing deaths that occurred in psychiatric centers to determine quality of care in those centers compared with that provided in other VA facilities. Preliminary data on 1989 deaths in psychiatric centers suggest that quality of care problems may still exist. GAO notes that the VA has not used information obtained from individual medical centers to make systemwide improvements and concludes that doing so could help ensure more uniform care for all VA patients.

Alcoholism Screening Procedures Should Be Improved (GAO/HRD-91-71, Mar. 27, 1991)

Alcoholism is a frequently overlooked health problem despite its significant medical, economic, social, and legal consequences. GAO looked at how physicians detect alcohol problems among veterans who have applied for treatment at medical centers. During a 10-day period in late 1990, GAO surveyed over 2,000 veterans who had sought health care at five VA medical centers. The information from the survey strongly suggest that 29 percent of the veterans have alcohol problems, and suspicions were raised about an additional 14 percent of the veterans raised about an additional 14 percent of the veterans. Yet the five centers provided alcohol treatment to fewer than 3 percent of the veterans who had sought care during fiscal year 1990. Because GAO found that the screening practices for alcoholism varied widely at the five centers, it recommended that each medical center systematically screen veterans for alcohol problems when they first apply for health care.

Delays in Awarding Major Construction Contracts (GAO/HRD-91-84, May 30, 1991)

The VA's appropriation for fiscal year 1990 includes funding for 18 major construction projects, each estimated to cost \$2 million or more. VA's March 1991 letter to the Congress and to GAO correctly identified the 17 projects that were required but did not have working drawings on construction contracts awarded by September 30, 1990. In GAO's view, the contracting delays for 15 of the 17 projects do not constitute an impoundment of budget authority under the Impoundment Control Act. GAO is continuing to review the impoundment implications of VA's actions on the projects at the Dallas and Gainesville medical centers, however, and will report its concluding later. VA's actions for the other 15 projects show no intent to avoid using the funds for the purpose for which they were intended. VA has awarded or expects to award contracts for 13 of the 17 projects by September 1991.

Inadequate Controls Over Addictive Drugs (GAO/HRD-91-101, June 6, 1991)

Drug abuse in the United States is not limited to illegal drugs like heroin and "crack" cocaine; about 8.6 million Americans misused prescription drugs last year, and health care workers are particularly susceptible to such abuse because of their access to prescription drugs. The has inadequate internal controls over many addictive prescription drugs used in its health care system. Too many employees have access to pharmacy stocks of these drugs, and stocks are rarely inspected. Because of these weaknesses, pharmacy employees have been able to steal wide range of prescription drugs for years. VA managers often became aware of these thefts, which sometimes totaled thousands of doses, only after law enforcement agencies notified them of criminal activities involving VA drugs. In addition, large amounts of addictive prescription drugs may have been stolen without VA managers ever detecting the thefts.

Telephone Service Should Be More Accessible to Patients (GAO/HRD-91-110, July 31, 1991)

With few exceptions, the VA medical centers do not provide telephones in patients' rooms. If patients are ambulatory, they must use pay phones; otherwise, they have to rely on nurses to bring them phones. This is an inconvenience for the patient and means that nurses have to spend more time on nonclinical duties. VA can procure telephone and equipment with appropriated funds but has not done so because of the substantial cost involved. However, VA has options available under which it can provide telephone services to its patients and recoup at least part of the costs for providing such services.

OTHER

ACCESSIBILITY FOR THE DISABLED STANDARDS FOR ACCESS TO STATE DEPARTMENT-DESIGNED BUILDINGS OVERSEAS (GAO/NSIAD-91-170, APR. 3, 1991)

When building or renovating facilities in other countries, the State Department is subject to building guidelines issued in 1984 designed to provide disabled people with full access. However, the State Department did not adopt these standards until March 1990. Of 23 building designs completed between 1984 and 1990, only 3 were produced after the standards had been adopted. However, State Department officials said that accessibility features, like ramps and appropriately designed rest rooms, were incorporated in designs before 1990.

FEDERAL AID

Programs Available to State and Local Governments (GAO/HRD-91-93FS, May 22, 1991)

This fact sheet provides information on Federal financial assistance programs (grants and direct payments) for which State and local governments are eligible applicants. It discusses 606 Federal programs, with estimated obligations of \$155.3 billion, available to such governments in fiscal year 1990. In addition, it includes the Catalog of Federal Domestic Assistance number identifying the Federal funding agency, program name, types of financial assistance, eligibility, budget function, and estimated funds obligated.

FINANCIAL AUDIT

Farmers Home Administration's Financial Statements for 1989 and 1988 (GAO/AFMD-91-36, May 6, 1991)

GAO's opinion on the Farmers Home Administration's (FmHA) consolidated financial statements is qualified for both fiscal years 1989 and 1988, because GAO was unable to satisfy itself that the acquired farm and rural housing property accounts were presented fairly. Specifically, GAO's opinion discloses that (1) accounting records used to support the reported amount of FmHA's acquired property were inaccurate and (2) reports produced by the Acquired Property Tracking System were not properly reconciled with the detailed acquired property files at FmHA field offices. GAO's report on FmHA's internal control structure discusses the problem with the Acquired Property Tracking System and an additional internal control weakness related to the new farm loan classification system's inability to project loan losses on FmHA's \$22 billion direct farm loan portfolio. GAO has identified FmHA as a high-risk area within the Federal Government, and this report discusses the nature and extent of problems associated with FmHA systems and programs.

NUTRITION MONITORING

Mismanagement of Nutrition Survey Has Resulted in Questionable Data (GAO/RCED-91-117, July 26, 1991)

Concerns about food safety and Americans' nutritional status point to the need for reliable, timely information on food use and U.S. dietary habits. The Department of Agriculture's Nationwide Foods Consumption Survey, completed most recently in 1987-88, is the Government's major survey on food and nutrition consumption. However, methodological problems, deviations from the survey's original design, and lax controls over the collection and processing of the results all raise doubt about the quality and usefulness of the most recent survey. Most importantly, results from the survey may not be representative of the U.S. population because of low response rates. Agriculture's Human Nutrition Information Service and Food and Nutrition Service (FNS) poorly managed the contract for the 1987-88 survey, at times violating key internal controls meant to safeguard the Government's best interests. The contracting officer's representative improperly approved changes without consulting the contracting officer. The contracting officer exercised no oversight during much of this time. As a result, the contractor did not complete key procedures required by the contract. These actions increased the contract's costs and delayed its completion by 2 years.

PAY AND BENEFITS

Data on Energy Employees Who Retired or Resigned in Fiscal Year 1989 (GAO/GGD-91-14BR, Oct. 25, 1990)

Questions continue to be raised about the Federal Government's ability to hire and retain high-quality workers. Many studies by GAO and others have concluded that noncompetitive Federal salaries contribute to Federal recruitment and retention problems. This briefing report contains information on former Department of Energy employees at grade 13 and above who retired or resigned during fiscal year 1989. GAO found that 43 of 78 employees who left Energy that year took private sector jobs that paid more than the Government did—up to \$15,000 more in some cases.

SMALL BUSINESS

Efforts to Improve Activities of the Service Corps of Retired Executives (GAO/RCED-91-5, Nov. 20, 1990)

The Service Corps of Retired Executive (SCORE) is a voluntary nonprofit organization whose primary purpose is to apply the experience of its counselors in solving the problems of small businesses. This report discusses (1) how SCORE operates and what services it provides and (2) several managerial and administrative issues, including SCORE's management information system, the Small Business Administration's (SBA) oversight of SCORE chapters, the chapters' interaction with the Small Business Development Center Program, evaluations of counselors' performances, and funding for clerical support and travel. GAO believes that SCORE chapters can provide counseling workshops with modest financial and administrative support from SCORE headquarters or SBA. Some chapters, however, may not need large amounts of funds because facilities and/or services are provided without charge by SBA or business associations, like the local chambers of commerce. GAO concludes that SCORE's recent efforts to improve chapter operations by issuing reporting guidelines and revoking charters of chapters that do not improve their performance are a step in the right direction. GAO realizes that SCORE's members are volunteers who provide valuable assistance to SBA and the small business community; nevertheless, accurate reporting of chapters' counseling sessions and workshops are important for improving management.

TRANSPORTATION

Status of GAO's Open Recommendations on Transportation Policies and Programs (GAO/RCED-91-112, Apr. 10, 1991)

In January 1991, GAO issued its annual report summarizing findings and open recommendations resulting from GAO work at Federal agencies for which satisfactory legislative or administrative actions had not been completed. That report discussed over 2,200 GAO recommendations that remained open as of September 30, 1990. This report on 142 open recommendations—138 in the transportation area and four in related areas—is being issued as a separate document to focus attention on matters of primary interest to congressional committees with transportation-related responsibilities.

WORKFORCE ISSUES

Employment Practices in Selected Large Private Companies (GAO/GGD-91-47, Mar. 13, 1991)

As part of an effort to assess the Government's ability to attract and retain employees, GAO examined employment practices in the non-Federal sector that may have applications in the Government. GAO surveyed large companies with many employment locations around the country. This report presents the results of that survey concerning recruiting and hiring practices; benefit programs; pay practices; and other programs—planned or in place—dealing with family concerns, alternatives to traditional work arrangements, older workers, and managing an increasingly diverse work force.

1990 CENSUS

Reported Net Undercount Obscured Magnitude of Error (GAO/GGD-91-113, Aug. 22, 1991)

GAO estimates that the 1990 census contained a minimum of 14.1 million gross errors and perhaps as many as 25.7 million errors, depending on how broadly census error defined. In either case, these are substantially more errors than indicated by the Census Bureau's widely reported 1990 census undercount of about 5.3 million persons. A focus on the net undercount obscures the true magnitude of the error in the census because, while millions of people were missed by the census, millions of other people were improperly counted. Examining the amount of gross error, therefore, provides a more complete picture of the quality of the census. In addition, the 1990 census contained proportionately more errors than the 1980 census. The estimated minimum number of errors in the 1980 census (7.8 million) represented about 3.4 percent of the 1980 count in contrast to 1990, when the minimum (14.1 million errors) represented about 5.7 percent of the count.

1990 CENSUS ADJUSTMENT

Estimating Census Accuracy—A Complex Task (GAO/GGD-91-42, Mar. 11, 1991)

Decennial census counts play an important role in reapportioning the House of Representative and in redrawing congressional, State, and municipal legislative district lines. However, the census has historically undercounted the population, especially black persons; undercounting can create inequities in political representation and the distribution of Federal funds. GAO reviewed the Census Bureau's procedures for estimating the accuracy of the census counts in the 1988 dress rehearsal—the final precensus test. This report focuses on the post-enumeration survey, which is the key census activity for a possible adjustment. GAO discusses a number of major hurdles to completing a high-quality post-enumeration survey in 1990.

APPENDIX III—FISCAL YEAR 1991 TESTIMONY RELATING TO ISSUES AFFECTING THE ELDERLY

GAO testified 35 times before congressional committees during fiscal year 1991 on issues relating to older Americans. Of the testimonies, 16 were on health issues, 1 on a housing issue, 6 on income security issues, 4 on social services issues, 2 on veterans' issues, and 6 on other issues.

HEALTH

Access to and utilization of the Ombudsmen Program Under the Older Americans Act, by Eleanor Chelimsky, Assistant Comptroller General for Program Evaluation and Methodology, before the Subcommittee on Aging, Senate Committee on Labor and Human Resources (GAO/T-PEMD-91-11, June 13, 1991)

The national ombudsmen program was created in 1975 in response to incidents of grossly inadequate care and abuse of residents in nursing homes. Ombudsmen investigate and resolve complaints made by or on behalf of residents, monitor laws governing elderly persons living in facilities, and provide information on long-term care options. The Administration on Aging, through its 10 regional offices, oversees and distributes funds earmarked for State ombudsmen programs. The Administration also provides technical support and guidance to State and local ombudsmen, collects data on their activities from each state, and presents a yearly summary report to the Congress. GAO testified on (1) use of the ombudsmen program by nursing home or board and care residents and how that use varies across States, (2) barriers preventing access by ombudsmen to residents, and (3) the likely impact of the program, as well as what impact data are being collected by the Administration on Aging and the States.

Canadian Health Insurance: Lessons for the United States, by Charles A Bowsher, Comptroller General of the United States, before the House Committee on Government Operations (GAO/T-HRD-91-35, June 4, 1991)

Canada has been more successful than the United States in controlling the growth in health care spending, even while providing health insurance to all its residents. Canada's success is based on the following three principles: universal health coverage, uniform reimbursement rules, and systemwide spending controls. If the universal coverage and single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for the millions of Americans who are now uninsured. Enough would be left over to reduce, or possibly even eliminate, copayments and deductibles, if that were deemed appropriate. The Canadian system is not without flaws, however. The Canadian method of controlling hospital costs has limited the use of expensive, high-technology diagnostic and surgical procedures. As a result, waiting lines, or queues—sometimes months long—have developed for some specialty surgical care services, like cardiac bypass surgery, lens implants, and magnetic resonance imaging. While the U.S. can learn from the Canadian model, a reformed U.S. system should also build upon the unique strengths of the existing U.S. Health care structure. The continuing development of advanced medical technology; detailed management information systems; and the flexibility to incorporate alternative service delivery mechanisms, like health maintenance organizations, are characteristics of the U.S. system that should be preserved.

Health Care: Limited State Efforts to Assure Quality of Care Outside Hospitals, by Lawrence H. Thompson, Assistant Comptroller General for Human Resources Programs, before the Subcommittee on Regulation, Business Opportunities, and Energy, House Committee on Small Business (GAO/T-HRD-91-20, Apr. 29, 1991)

Over the past 20 years, medical and diagnostic procedures that were traditionally done in hospitals have increasingly been done in "freestanding" facilities, like am-

bulatory care centers and emergency centers. Relocating complex and risky medical procedures, like surgeries and radiology services, to these freestanding facilities has prompted concerns about the quality of care provided. GAO testified that States that license freestanding providers generally establish minimum quality assurance requirements, conduct on-site inspections to determine compliance with requirements, and have the authority to impose sanctions against providers when necessary. States have been slow, however, to license freestanding providers. Further, they have limited plans to expand licensing requirements. Unless the HHS or a reputable private accrediting organization is monitoring an unlicensed freestanding facility, consumers have little assurance about the quality of care being offered.

Long-Term Care Insurance: Risks to Consumers Should Be Reduced, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-91-14, Apr. 11, 1991)

By June 1990, about 1.6 million Americans had bought long-term care insurance as a protection against the devastating costs of nursing home care. Although State standards and long-term care insurance policies have improved over the past 5 years, consumers still face considerable risks in purchasing policies. Due to the absence of uniform terms and definitions, it is hard or even impossible for a consumer to understand when benefits will be paid or to compare the benefits and value of policies. Consumers also risk unpredictable premium hikes that can make it difficult for them to keep their policies. Yet if the policies are allowed to lapse, consumers lose the money they invested in premiums. GAO believes that the Congress should consider passing legislation—as was done in the case of Medigap insurance—that would set minimum standards for long-term care insurance.

Managed Care: Oregon Program Appears Successful but Expansions Should Be Implemented Cautiously, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce (GAO/T-HRD-91-48, Sept. 16, 1991).

Under its demonstration proposal, Oregon plans to expand its prepaid managed care activities as part of a larger proposal to restructure its Medicaid program. Oregon plans to institute a more cost-effective Medicaid program while substantially expanding eligibility by (1) establishing a priority list of covered services and (2) instituting a statewide managed care program. While financial oversight activities and reporting requirements could be strengthened, GAO concludes that Oregon has designed, implemented, and operated a Medicaid managed care program that provides access to quality care for most of its recipients of Aid to Families With Dependent Children. GAO is uncertain, however, whether Oregon can implement the statewide managed care system as rapidly as proposed, and whether financial oversight and monitoring activities will be adequate. In GAO's view, the apparent success of the Oregon program to date may be credited in large part to the deliberate pace with which it was implemented with proper State oversight. Moving to a statewide system in only 1 year seems very difficult. It is unclear that Oregon can establish the provider network to support the large enrollment that quickly. The State assumes that HMOs not now participating in the Medicaid program will become interested and that physician care organizations now participating will convert to full capitation or consolidate with other plans. GAO believes that the HCFA should require Oregon to demonstrate that there is adequate provider capacity and enough oversight in place before it is allowed to implement the demonstration project.

Medicaid Formula: Fairness Could Be Improved, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Human Resources and Intergovernmental Relations, House Committee on Government Operations (GAO/T-HRD-91-5, Dec. 7, 1990)

The current Medicaid formula, which was adopted in 1965, has two main objectives: (1) reducing differences among States in medical care coverage of the poor and (2) distributing fairly the burden of financing program benefits among the States. GAO testified that these objectives have not been met. Nationwide, 75 percent of those below the poverty line are covered; however, this coverage varies from 37 percent in Idaho to 111 percent in Michigan. Also, States face varying burdens in financing the cost of providing for those in need. This happens, in part, because the formula does not target most Federal funds to States with the greatest needs; that is, those with weak tax bases and high concentrations of poor people. In GAO's view, the congress may wish to consider revising the formula to accommodate these concerns.

Medicare: Further Changes Needed to Reduce Program Costs, by Charles A. Bowsher, Comptroller General of the United States, before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-91-34, June 13, 1991)

Medicare pays for about one-quarter of all hospital and physician services in this country and has become the fourth largest category of Federal expenditures, surpassed only by defense, Social Security, and interest payments on the national debt. As such, the Medicare program bears a responsibility to be a leader in health care reform, and, to a large extent, Medicare has met its responsibility in this area. Despite efforts to constrain costs, however, Medicare spending and beneficiary out-of-pocket expenses have risen at troubling rates. Medicare expenditures rose from about \$70 billion in 1985 to \$106 billion in 1990, while average beneficiary out-of-pocket costs rose from about \$630 to over \$1,000 for Medicare-covered services. Medicare's high cost and continued rapid growth are evidence of inadequate economic incentives for patients and providers to contain costs. Consequently, much remains to be done to translate recent payment reforms into fully functioning systems. This report identifies issues that the Congress may want to examine to (1) help endure that current Medicare reforms achieve their objectives and (2) identify additional opportunities to reduce Medicare beneficiary and program costs.

Medicare: Millions in Potential Recoveries Not Being Sought by Contractors, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Subcommittee on Oversight, House Committee on Ways and Means (GAO/T-HRD-91-8, Feb. 26, 1991)

At a time when Medicare costs are soaring, GAO believes that Medicare carriers should be trying to recover the hundreds of millions of dollars potentially owed to the Medicare program by other insurers. A recently initiated IRS/SSA data match and a HHS regulation make it imperative that this problem be addressed immediately. The data match could add several million more claims to the existing backlog of mistaken Medicare payments. Further, the HHS regulation limits the time that contractors have to initiate recovery action after they identify another insurer. Thus, unless contractors are given enough resources to begin recovering the mistaken payments, hundreds of millions of dollars owed to Medicare will never be recovered. GAO believes that the additional funding for contractor recovery of mistaken payments should return considerably more than the dollars spent.

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs, by Janet L. Shikles, Director of Health Financing and Policy Issues, before the Senate Special Committee on Aging (GAO/T-HRD-91-12, Mar. 13, 1991)

After almost 4 years of operation, the peer review organization program has not provided the intended assurance that Medicare beneficiaries enrolled in risk Health Maintenance Organizations are receiving quality health care. The program's effectiveness has been impeded by a lack of strong central management from the Health Care Financing Administration.

Mental Health Grants: Funding Not Distributed in Accordance With State Needs, by Linda G. Morra, Director of Human Services Policy and Management Issues, before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce (GAO/T-HRD-91-32, May 16, 1991)

GAO discussed how \$1.3 billion in Federal funds are being distributed under the Alcohol, Drug Abuse, and Mental Health block grant programs. Recent formula changes have improved the targeting of the block grant to States in relation to their population at risk of drug abuse. Populations at risk of mental health and alcohol problems, however, will have little influence on the distribution of block grant funding when hold-harmless funding is eliminated. Within States, the current formula's allocation of funding between mental health and substance abuse is unrelated to State differences in mental health needs. Allocating mental health funds through a separate apportionment formula, as proposed in pending legislation, would significantly improve the targeting of mental health funds in accordance with State needs. It would, however, redistribute mental health funds across States; some would gain funds and others would lose them.

Nonprofit Hospitals: Better Standards Needed for Tax Exemption, by Mark V. Nadel, Associate Director for National and Public Health Issues, before the House Committee on Ways and Means (GAO/T-HRD-91-43, July 3, 1991)

GAO found that the link between tax-exempt status and the provision of charitable activities for the poor or underserved is weak for many nonprofit hospitals. Typically, in the States GAO reviewed, large urban teaching and public and public hospitals provided a disproportionate share of charity and other unreimbursed care.

Private Health Insurance: Problems Caused by a Segmented Market, by Mark V. Nadel, Associate Director for National and Public Health Issues, before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-91-21, May 2, 1991)

GAO testified that small businesses face particular difficulties in obtaining affordable private health insurance for their employees. Small businesses, generally those

with fewer than 25 employees, bear higher costs than do larger companies, and their costs are rising more rapidly. A growing percentage of small firms do not offer their employees insurance benefits; about one-third of all the uninsured—about 10 million people—work for or are dependents of people who work for small businesses. GAO discusses efforts aimed at reforms targeted toward the small group health insurance market, but says that it will be difficult to move from the current segmented system into one that spreads risks more broadly. Also, reform initiatives do not address the problems of ever increasing health care costs, nor can they directly address the different regulatory treatment of health benefit plans resulting from the Employee Retirement Income Security Act of 1974.

Retiree Health: Company-Sponsored Plans Facing Increasing Costs and Liabilities, by Gregory J. McDonald, Associate Director for Income Security Issues, before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-91-25, May 6, 1991)

Company group health plans have played a major role in providing active and retired workers and their dependents with access to needed medical services. Confronted by cost, accounting, and funding constraints, companies are rethinking their commitment to providing retiree health benefits. Some companies have changed their health plan provisions to shift some costs to retirees and/or cut benefits, and retirees have limited protection under current law against such actions. This testimony describes (1) the extent of plan coverage and the cost of benefits, (2) the level of companies' retiree health liabilities, (3) advance funding options, (4) the extent to which companies are modifying their plans, (5) workers' protection under current law, and (6) congressional options.

Rural Hospitals: Closures and Issues of Access, by Mark V. Nadel, Associate Director for National and Public Health Issues, before the Task Force on Rural Elderly, House Select Committee on Aging (GAO/T-HRD-91-46, Sept. 4, 1991)

Between 1980 and 1988, 200 rural hospitals closed. GAO testified that HHS needs to actively work on a coordinated approach to identifying and helping communities where essential hospitals are at risk. In GAO's view, the issue is not one of authority or available resources but rather how HHS uses its authority to deliver the right kinds of assistance to the right hospitals. Further, if the Congress decides to take additional action to help rural hospitals, funding should (1) target at-risk, essential, and potentially viable hospitals; (2) be enough to make a difference in financial status for these hospitals; and (3) help a community strengthen access to alternative sources of care if a hospital providing essential services is not likely to remain viable.

Substance Abuse Funding: High Urban Weight Not Justified by Urban-Rural Differences in Need, by Lawrence H. Thompson, Assistant Comptroller General for Human Resources Programs, before the Senate Committee on Labor and Human Resources (GAO/T-HRD-91-38, June 25, 1991)

Under the apportionment formula used to distribute \$1.3 billion in Federal funds provided by the Alcohol, Drug Abuse, and Mental Health block grant program, urban States receive higher per capita funding than can be justified by studies of urban-rural differences in drug abuse or the cost of providing services. Funding was not systematically targeted to low-income States, as was intended by 1988 legislation. Although a high weight on urban population may serve as a proxy for the cost of providing services, GAO believes that it would be preferable to introduce a cost factor directly into the formula. Legislation pending before the Congress would distribute block grant funds so that they more closely reflect high concentrations of high-risk people, the cost of providing services, and State taxpayers' ability to fund service needs.

U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform, by Charles A. Bowsler, Comptroller General of the United States, before the House Committee on Ways and Means (GAO/T-HRD-91-16, Apr. 17, 1991)

Today, over 12 percent of U.S. national income goes for health care services, and by the year 2000, this amount is projected to grow to nearly 15 percent of the gross national product. At that point, \$300 billion will have been added to national health spending—an amount equivalent to the current defense budget. The Comptroller General concludes that piecemeal reforms, whether undertaken by business or the government, are unlikely to rein in the growth of national health spending substantially. If the spiral in health care is to be slowed, reform must be comprehensive. GAO believes that any reform should include three elements found in approaches used by other countries to successfully restrain health care spending: (1) insuring each individual; (2) instituting uniform payment rules for health care services; and (3) setting caps on total expenditures for major provider categories, like hospitals, physicians, and technology.

HOUSING

Counting the Homeless: Limitations of 1990 Census Results and Methodology, by L. Nye Stevens, Director of Government Business Operations Issues, before the Subcommittee on Government Information and Regulation, Senate Committee on Governmental Affairs, and the Subcommittee on Census and Population, House Committee on Post Office and Civil Service (GAO/T-GGD-91-29, May 9, 1991)

GAO testified on the Census Bureau's 1990 Shelter and Street Night (S-Night) Enumeration, which was designed to count people who might otherwise have been missed by the census. The census and S-Night were not designed to, and did not, provide a complete count of the Nation's homeless. The Bureau consistently has warned data users that the decennial census is not the appropriate vehicle for determining the extent of homelessness. In past reports, GAO has discussed efforts that extend well beyond the census that need to be done to estimate the number of homeless. As a result of methodological and operational weaknesses, however, the Bureau added fewer people to the census count through S-Night than it probably could have if it had aggressively pursued the daytime method early in the decade. S-Night is an example of what has been one of GAO's major concerns for several years—that the late census planning and the failure to fully consider and evaluate alternatives that characterized the 1990 census must be avoided for the 2000 census.

INCOME SECURITY

Federal Agencies Need SSA's Death Information to Avoid Erroneous Payments, by Lawrence H. Thompson, Assistant Comptroller General for Human Resources Programs, before the Subcommittee on Oversight, House Committee on Ways and Means (GAO/T-HRD-91-6, Feb. 6, 1991)

As a result of its contacts with family members, funeral homes, and other Federal and State agencies, the SSA maintains the most comprehensive death information in the Federal Government—if not the Nation. GAO found that Federal and State agencies, which are erroneously paying out millions of dollars each month to dead beneficiaries, rarely avail themselves of SSA's comprehensive death information. Instead, agencies continue to rely on voluntary reporting of deaths in order to stop paying or to adjust survivor benefits. GAO notes the existence of barriers to governmentwide use of SSA's purchased death information, including (1) State-negotiated restrictions on the use of data by other Federal agencies and (2) States' desire to be compensated by each Federal agency's use of the death information they provide. However, this State death information is a critical internal control for reducing erroneous payments in both Federal and State benefit programs, and GAO believes that it should be provided to SSA without restrictions for use by Federal and State benefit programs. GAO concludes that legislation is needed to enable SSA to more easily disclose the purchased data to other agencies. In addition, the Office of Management and Budget should require governmentwide use of SSA's comprehensive file of death information.

GAO Views on H.R. 2898, the "Social Security Protection Act of 1991," by Harry S. Havens, Assistant Comptroller General, before the Subcommittee on the Legislative Process, House Committee on Rules (GAO/T-AFMD-91-11, Sept. 26, 1991)

GAO testified on H.R. 2898's proposed treatment of the administrative expenses of the Social Security Old-Age, Survivors, and Disability Insurance programs. From fiscal year 1986 to the enactment of the Budget Enforcement Act of 1990, the receipts and disbursements of the programs were off-budget but were included in the deficit calculations of the Gramm-Rudman-Hollings legislation. H.R. 2898 would provide explicitly that program administrative expenses not be counted for purposes of the budget submitted by the President, the congressional budget, or Gramm-Rudman Hollings; not be considered to be in any discretionary spending category; and be exempt from any sequestration order. GAO does not favor excluding program administrative expenses from the discretionary spending category. If, however, the Congress does enact such a change, GAO also favors prohibiting an appropriate adjustment in the discretionary spending limits.

Insurance Company Failures Threaten Retirement Income. by Joseph F. Delfico, Director of Income Security Issues, before the Subcommittee on Select Revenue Measures, House Committee on Ways and Means (GAO/T-HRD-91-41, June 27, 1991)

Recent developments in the insurance industry have raised concern about the security of private pensions. Between 1975 and 1990, 170 life insurance companies failed—40 percent of these during the last 2 years. While most of these failures have been small, the Executive Life Insurance Company was placed into conservatorship in April 1991; if this firm fails, it would be the largest U.S. insurance company ever

to do so. The basic problem is that despite a Federal pension guaranty agency and a network of state insurance guaranty associations, some pensioners risk losing a portion of retirement income due to insurance company insolvency. In some cases, pensions have no guaranty coverage, and in others, they receive incomplete protection. Furthermore, pensioners are not routinely informed when they lose Federal protection. This testimony addresses the guaranty system now protecting pension plan annuitants and how the system applies to pension plan investments.

Private Pensions: Risks to Retirees Posed by Insurance Company Failures, by Joseph F. Delfico, Director of Income Security Issues, before the Subcommittee on Retirement Income and Employment, House Select Committee on Aging (GAO/T-HRD-91-23, Apr. 30, 1991)

Insurance industry and government data suggest that 3 to 4 million retirees and their surviving dependents receive annuities that their pension plans bought for them from life insurance companies. Even though pension plan benefits are guaranteed by Federal law, these pensioners lost their protection when they became dependent on an insurance company for retirement income. Furthermore, retirees holding these annuities may be unaware that Federal guarantees do not extend to them. Without Federal guarantees, pensioners holding insurance annuities must rely on State guarantees, which provide incomplete coverage. As a result, some pensioners could lose all or part of their pension benefits in the wake of insurance company failures. Due to limited data, GAO was unable to determine the likelihood or value of losses by annuitants. However, 170 life insurance companies have failed since 1975—40 percent of them in the last 2 years.

Service to the Public: How Effective and Responsive Is the Government?, by Lawrence H. Thompson, Assistant Comptroller General for Human Resources Programs, before the House Committee on Ways and Means (GAO/T-HRD-91-26, May 8, 1991)

Are the American people getting their money's worth from the Federal Government? A lot will be required of the Government and its managers to operate more efficiently and effectively in the years ahead, GAO testified, but positive signs are on the horizon. In general, the problems of the Government are its management, not its people. To improve management, agencies need to develop strategies to overcome disruptive effects of leadership changes, such as long-range plans and sound financial management systems. They also must become accustomed to operating with the customer's needs in mind and to measure performance accordingly. Congress can play an important role in this type of reform by supporting agency efforts in the following three areas: quality management, stewardship of public funds, and more systematic program evaluation.

Social Security: Reforms in the Disability Determination and Appeals Process, by Joseph F. Delfico, Director of Income Security Issues, before the Subcommittee on Social Security, House Committee on Ways and Means (GAO/T-HRD-91-24, May 2, 1991)

Evidence suggests that the quality of State disability decisions has declined over the last few years, while the workload for the State Disability Determination Services (DDS) has significantly increased. The success rate for claimants who appeal to administrative law judges (ALJ) has risen in the last several years to about 63 percent, calling into question the worth of the denial decisions made by state DDSs. One difference between the two decision processes is the face-to-face appearances of the claimant: ALJs ask claimants direct questions, while DDSs review case files only. GAO believes that face-to-face meetings, on a limited basis, at the initial decision level could improve DDS determinations. GAO also testified on proposed legislation to eliminate the reconsideration level of appeal.

SOCIAL SERVICES

Adequacy of the Administration on Aging's Provision of Technical Assistance for Targeting Services Under the Older Americans Act, by Robert York, Acting Director for Program Evaluation in Human Services Areas, before the Subcommittee on Human Resources, House Committee on Education and Labor, and the House Select Committee on Aging (GAO/T-PEMD-91-3, Apr. 25, 1991)

Several studies suggest that, in addition to having a higher poverty rate, elderly minorities have greater needs in areas like health services and supportive social services. Despite these needs, many minority elderly do not receive adequate services because of access problems, cultural barriers, and lack of awareness about the availability of these services. This testimony addresses the targeting of minorities in programs and services administered by the Administration on Aging. GAO discusses (1) the data that are available to assess the effectiveness of targeting, (2) how the Administration provides technical assistance on targeting to State units on aging,

(3) the unmet technical assistance needs of State units with regard to targeting, and (4) the ability of the Administration to administer Older Americans Act programs given its current location within the Office of Human Development Services of HHS.

Effectiveness of Reporting Laws and Other Factors in Identifying, Preventing, and Treating Elder Abuse, by Gregory J. McDonald, Associate Director for Income Security Issues, before the Subcommittee on Human Services, House Select Committee on Aging (GAO/T-HRD-91-27, May 15, 1991)

The term "elder abuse" refers to the abuse, the neglect, or the exploitation of people aged 60 or older. To help identify victims of elder abuse, nearly every State has passed laws on the reporting of elder abuse. Certain persons in States with mandatory reporting laws are required to report incidences of elder abuse but such reporting is not required in States with voluntary reporting laws. GAO concludes that this debate over mandatory versus voluntary reporting laws will yield uncertain answers on the relative effectiveness of these laws and that other factors are more important in identifying, preventing, and treating cases of elder abuse.

The Administration on Aging: Harmonizing Growing Demands and Shrinking Resources, by Eleanor Chelimsky, Assistant Comptroller General for Program Evaluation and Methodology, before the Subcommittee on Human Services, House Select Committee on Aging (GAO/T-PEMD-91-9, June 12, 1991)

GAO testified on (1) the match between the Administration on Aging's resources, on the one hand, and its mandated mission and services, on the other; (2) how the Administration provides technical assistance and oversight to State units on aging; and (3) whether the technical assistance provided by the Administration meets the needs of State units. GAO believes that more consideration needs to be given to the impact of declining staff and travel funds on the ability of the Administration to perform its oversight functions and to deliver the required technical assistance to State units and area agencies on aging. GAO also believes that the technical assistance needs of the State units need to be better identified, prioritized, and resolved. Finally, it seems likely that some overall conciliation process will be needed to harmonize the Administration's increasing responsibilities, the elderly population's growing demands for services, and shrinking funds.

Vocational Rehabilitation: Improved Federal Leadership Could Help States Focus Services on Those With Severe Handicaps, by Franklin Frazier, Director of Education and Employment Issues, before the Subcommittee on Select Education, House Committee on Education and Labor (GAO/T-HRD-91-10, Sept. 26, 1991)

Due to limited program funding, vocational rehabilitation now serves only a fraction of those potentially eligible. Program officials expect the number of handicapped Americans to grow as the population ages and medical technology prolongs the lives of the seriously-injured. Under the Rehabilitation Act of 1973, States that cannot provide services to all eligible applicants must give individuals with the most severe handicaps first priority for rehabilitation services. GAO testified that most States have not implemented this order-of-selection provision, although the States that have found it to be a fair and manageable way to set priorities for limited resources. Overall, these States have a higher percentage of clients with severe handicaps in their caseload. GAO believes that guidance and monitoring regarding how States implement this procedure should be improved.

VETERANS

Alcoholism Screening Procedures at VA Medical Centers, by David P. Baine, Director of Federal Health Care Delivery Issues, before the Senate Committee on Governmental Affairs (GAO/T-HRD-91-15, Apr. 18, 1991)

Alcoholism is a frequently overlooked health problem despite its significant medical, economic, social, and legal consequences. GAO looked at how physicians detect alcohol problems among veterans who have applied for treatment at VA medical centers. During a 10-day period in late 1990, GAO surveyed over 2,000 veterans who had sought health care at five VA medical centers. The information from the survey strongly suggests that 29 percent of the veterans have alcohol problems, and suspicions were raised about an additional 14 percent of the veterans surveyed. Yet the five centers provided alcohol treatment to fewer than 3 percent of the veterans who had sought care during fiscal year 1990. Because GAO found that the screening practices for alcoholism varied widely at the five centers, it recommends that each medical center systematically screen veterans for alcohol problems when they first apply for health care.

Controls Over Addictive Drugs in VA Pharmacies, by David P. Baine, Director of Federal Health Care Delivery Issues, before the Subcommittee on Oversight and In-

vestigations, House Committee on Veterans' Affairs (GAO/T-HRD-91-36, June 19, 1991)

Drug abuse in the United States is not limited to illegal drugs like heroin and "crack" cocaine; about 8.6 million Americans misused prescription drugs last year, and health care workers are particularly susceptible to such abuse because of their access to prescription drugs. The VA has inadequate internal controls over many addictive prescription drugs used in its health care system. Too many employees have access to pharmacy stocks of these drugs, and stocks are rarely inspected. Because of these weaknesses, pharmacy employees have been able to steal a wide range of prescription drugs for years. VA managers often became aware of these thefts, which sometimes totaled thousands of doses, only after law enforcement agencies notified them of criminal activities involving VA drugs. In addition, large amounts of addictive prescription drugs may have been stolen without VA managers ever detecting the thefts.

OTHER

Bureau of Indian Affairs' Efforts to Reconcile and Audit the Indian Trust Funds, by Jeffrey C. Steinhoff, Director of Civil Audits, before the Subcommittee on Interior and Related Agencies, House Committee on Appropriations (GAO/T-AFMD-91-2, Apr. 11, 1991)

The Department of the Interior manages the Indian trust funds, which at the end of fiscal year 1990 included about 2,000 tribal and 300,000 individual Indian money accounts with balances totaling over \$2 billion. Money in the trust funds is derived from a variety of sources: payments of claims; oil, gas, and mineral royalties; land use agreements; and investment income. Over the years, audit reports have cited many weaknesses in the control and oversight of these accounts by the Bureau of Indian Affairs. As a result, the Bureau has lost credibility with the account holders. GAO testified on Bureau efforts to reconcile and audit the Indian trust funds, a major undertaking scheduled to begin in the summer of 1991. The Bureau will try to identify and correct balances in the accounts, many of which are 50 to 100 years old—a task GAO compares with determining the correct balance of a personal checking account that was active for over 50 years but not reconciled periodically.

Components of the 1990 Census Count, by L. Nye Stevens, Director of Government Business Operations Issues, before the Subcommittee on Census and Population, House Committee on Post Office and Civil Service (GAO/T-GGD-91-8, Feb. 21, 1991)

The 1990 census population count came from three broad sources: (1) data that individuals and households provided on themselves; (2) data gathered from non-household sources, such as administrative records or neighbors; and (3) data generated through statistical methods, such as imputation. GAO testified that data are not available that show clearly how much each source contributed to the count, although it is clear that most of the data were supplied directly by households. An evaluation of the comparative quality of the three sources of data should provide insight into the best mix of methodologies to improve the cost effectiveness of future censuses.

Expanding the Role of Local Governments: An Important Element of Census Reform, by L. Nye Stevens, Director of Government Business Operations Issues, before the Subcommittee on Census and Population, House Committee on Post Office and Civil Service (GAO/T-GGD-91-46, June 15, 1991)

The success of the decennial census requires a strong partnership between the Census Bureau and local governments—one probably much stronger than commonly realized. During the 1990 census, local governments helped to determine what data would be collected on the census questionnaire, encouraged public participation through publicity and outreach efforts, and helped improve the completeness of the Bureau's address list and the accuracy of the population counts through the census local review program. A successful 2000 census demands that the Bureau and local governments work even more closely together throughout the coming decade. GAO believes that it is in the best interests of both the Bureau and the governments to make sure that their important partnership yields the most complete count possible.

Major Issues Facing the 102nd Congress, by Charles A. Bowsher, Comptroller General of the United States, before the Senate Committee on Governmental Affairs (GAO/T-OCG-91-1, Jan. 23, 1991)

GAO's 1988 transition series sought to alert the President-elect and the new Congress to the many challenges facing the Nation. This testimony updates the status of the issues GAO cited in 1988. The Comptroller General first reviews the overall state of the economy and the budget, cautioning that a protracted war in the Middle

East, the recession at home, and further increases in the cost of deposit insurance could trigger another explosive rise in the deficit over the next several years; the general fund deficit—excluding the surpluses in the Social Security and other trust funds—already appears likely to top \$400 billion in 1991. He then discusses critical policy problems in the following program areas: defense, the financial sector, health, transportation, agriculture, energy, the environment, financial management, and public service. In some cases GAO reports significant progress, but that is the exception. Many of the problems, including some of the most important ones like the thrift crisis, have become more severe. Given the rapid developments in international affairs—as evidenced by changes in the Warsaw Pact countries and by the economic and political integration of Western Europe—the Comptroller General believes that it is time to revisit the question: What is required of our government? If the United States is to succeed in this new world order, the Comptroller General believes that several prerequisites must be satisfied. First, we must have a Government that works, one that operates efficiently and effectively, both in its internal functions and in its delivery of services to the American people. To reach that goal, investment in Government, its people, its facilities, and its technology is needed. Second, we must have a Government whose financial performance relates properly to the national and world economy. For that to be achieved, the United States must move toward a long-term fiscal policy that recognizes the need for a much higher level of national savings. Third, we must have a financial system in whose safety and soundness the American people can have complete confidence, so that our market economy can effectively allocate capital to the most productive uses. To accomplish that, we must resolve the thrift crisis, restore the soundness of the banking industry, and ensure an efficient and effectively regulated structure of capital markets.

1990 Census: Applying PES Results and Evaluations to the Adjustment Decision, by L. Nye Stevens, Director of Government Business Operations Issues, before the Subcommittee on Census and Population, House Committee on Post Office and Civil Service (GAO/T-GGD-91-49, June 27, 1991)

In this testimony, a supplement to GAO's June 19 statement (see GAO/T-GGD-91-26), GAO discusses the results of the 1990 census Post Enumeration Survey (PES)—a central methodology that the Commerce Department is using to decide whether or not to adjust the 1990 census counts. While all measures of coverage error indicate that the 1990 census missed a greater percentage of the U.S. population than did the 1980 census, GAO believes that the dependability of the PES as a tool for adjusting census counts remains questionable. In the three weeks remaining before the deadline for an adjustment decision, the Commerce Department will have to grapple with some hard technical questions in deciding if adjustment would improve the accuracy of the counts, particularly at lower geographic levels.

1990 Census: Financial Preparations for a Possible Adjustment, by L. Nye Stevens, Director of Government Business Operations Issues, before the Subcommittee on Government Information and Regulation, Senate Committee on Governmental Affairs (GAO/T-GGD-91-26, June 19, 1991)

All measures of coverage error indicate that the 1990 census missed a greater percentage of the U.S. population than did the 1980 census, the first time in modern census history that the coverage rate did not improve over that of the previous census. Furthermore, the differential undercount between the undercount of blacks and the undercount of nonblacks was greater than at any time since the Bureau began measuring the differential in 1940. At this point, however, GAO is unable to assess the quality of the 1990 Post Enumeration Survey (PES)—a central methodology the Department of Commerce will use to decide whether or not to adjust census counts—because it has not had time to assess the results of the Census Bureau's evaluations of the survey. The quality of the survey data will influence Commerce's confidence in the PES when deciding on adjustment. In the final analysis, GAO testified, the Census Bureau and the Commerce Department will need to use available data and their informed judgment when deciding upon the technical quality of the PES.

APPENDIX IV—ONGOING GAO WORK AS OF SEPTEMBER 30, 1991, RELATING TO ISSUES AFFECTING THE ELDERLY

At the end of fiscal year 1991, GAO had 119 ongoing jobs that were directed primarily at the elderly, or had older Americans as one of several target groups. Of these, 55 were on health issues, 2 on housing, 20 on income security issues, 8 on social services issues, 29 on veterans' issues, and 5 on other issues.

HEALTH

- Accuracy of Medicare Facility Cost Report Data Bases
 Administration of Drugs in Board and Care Homes for the Elderly
 Alternative Resolution Procedures for Medical Malpractice Claims Involving Services Provided Through Medicare
 Automated Medical Records
 Case Management of Long-Term Care for the Elderly
 Changes in Hospital/HMO Prescription Drug Prices
 Comparison of Administrative Costs of International Health Care Systems
 Comparison of United States and Canadian Prescription Drug Prices
 Comparison of 1988 and 1989 Medigap Insurance Loss Ratio Experience
 Compatibility of State Agency Surveyors to Identify Hospitals That Are Not Complying With Medicare Requirements
 Conditions Affecting Utilization of Emergency Departments
 Costs and Services of End Stage Renal Disease Facilities
 Costs of Health Insurance to Business in the U.S. and Canada
 Department of Health and Human Services Health Information for Midlife and Elderly Women
 Diabetes in the Minority Population
 Do Interstate Differences in Health Care Spending Suggest Improvements in Federal Cost Containment Policy?
 Drug Utilization Reviews Under the State Medicaid Program
 Effect of External Utilization Management Firms' Decisions on the Quality of Health Care
 Effect of Medicare's Durable Medical Equipment Fee Schedule on Program Payments and Alternative Payment Approaches
 Efforts to Improve Small Business Employee Access to Health Care
 Equity of and Access to Indian Health Service
 Feasibility of Establishing a Separate Fee Schedule for Professional Services Provided by the Supplier Personnel
 Federal and State Efforts to Increase Organ Donation and Provisions for Equitable, Efficient, and Effective Procurement and Allocation of Organs
 Health Care Financing Administration's Oversight of Medicare's Risk HMO Program and the Humana Risk in Florida
 Health Care Financing Administration's Recoveries of Medicare Carrier Payments
 Health Insurance Waste and Abuse
 Hospital-Based and Freestanding Skilled Nursing Facilities' Costs
 Impact of Extending Medicare Secondary Payer Period for End Stage Renal Disease Beneficiaries
 Implementation of Medicare Insured Group Demonstration Project—Year Three
 International Comparison of Medical Malpractice and Quality Assurance Systems
 International Health Care Systems
 Long-Term Care Insurance Policyholder Protections
 Managed Care in the Medicaid Program
 Marketing of Long-Term Care Insurance
 Medical Malpractice Insurance Alternatives for Community and Migrant Health Centers
 Medicare's Effectiveness in Handling Beneficiary Complaints of Fraud and Abuse
 Medicare Payment Levels for CAT Scans and MRIs in Light of Increased Utilization of Such Specialized Technologies
 Medicare Payments for Durable Medical Equipment
 Medicare Payments to Home Health Agencies
 Medicare Payments to Physicians for Medically Directing Nurse Anesthetists
 Medicare System Sharing
 Medicare Technical Component Payments for MRI
 Methods to Prevent False Medicare Claims
 Methods Used to Fund Community Health Centers
 Multiple Copy Prescription Programs
 Oregon's Proposal to Contain Medicaid Costs by Rationing Health Care Services
 Peer Review Organization's Review of Ambulatory Surgery
 Recovery of Medicare Part B Overpayments
 Social Security and Family Support Administration's Medical Responsibilities for Identifying Liable Third Parties
 Source of Rising Hospital Costs
 State Initiatives to Achieve Universal Access to Health Care

- State Policy on Reimbursement for Disproportionate Share Hospitals in the Medicaid Program
- The Appropriateness of Medicare Payments for Durable Medical Equipment
- The District of Columbia's Medicaid Eligibility System and Its Input on Hospital Reimbursement
- The Magnitude of Medicare Credit Balances and the Impact on the Medicare Program

HOUSING

- Elderly Use of Housing Vouchers
- Problems with Housing the Mentally Disabled With the Elderly

INCOME SECURITY

- Annuitants From Pension Plan Terminations
- Benefits and Problems in Allowing Organizations Serving as Representative Payees to Charge Fees
- Department of Labor and Internal Revenue Service Actions on ERISA Violations Reported by Pension Plan
- Department of Labor and the Pension Benefit Guaranty Corporation Roles When Pension Plans Purchase Annuities
- Effectiveness of the Social Security Administration's Effort to Assist Supplemental Security Income Applicant's Application for Food Stamps
- Examine the Results of Internal Revenue Service/Social Security Administration Efforts to Reconcile Differences in Wage Reports Filed for Fiscal Year 1978-87
- Financial Assumptions Used in Estimating Defined-Benefit Pension Plans' Liabilities
- Internal Revenue Service Refund Information Could Permit the Social Security Administration to Credit Some Currently Uncredited Earnings to the Correct Accounts
- Monitoring the Bureau of Indian Affairs' Efforts to Reconcile Indian Trust Funds Pension Benefit Guaranty Corporation Fiscal Year 1991 Financial Audit
- Pension Benefit Guaranty Corporation's Collection of Premiums Under the Employee Retirement Income Security Act of 1974
- Pension Fund Investments in Low- and Moderate-Income Housing Projects
- Pension Survivor Benefits After Implementation of the 1984 Retirement Equity Act
- Quality of Financial Statement Audits of Private Sector Employee Benefit Plans
- Selected Employee Benefit Taxation Issues
- Social Security Administration's Acquisition and Processing of Death Information
- Spousal Consent Forms Mandated Under the 1984 Retirement Equity Act
- Tax Treatment of Long-Term Care Insurance
- The Primary Cause of Overpayments at the Social Security Administration
- Utilization of Simplified Employee Pensions

SOCIAL SERVICES

- Adequacy of Services Provided to Disabled Persons
- An Analysis of State Eldercare Policies Submitted to the Administration on Aging
- Cost Sharing Under the Older Americans Act Program
- Poverty Among the Elderly
- Public/Private Partnerships Under the Older Americans Act
- Reorganization of the Administration on Aging
- Social Indicators: Comparing Rural Areas and Inner Cities
- Vocational Rehabilitation Services Authorized Under the Rehabilitation Act of 1973

VETERANS

- Allegations of Poor Quality Care in Selected Department of Veterans Affairs Medical Centers
- Comparison of Benefits Provided to Disabled Veterans in United States and Foreign Countries
- Department of Veterans Affairs Copayment Exemption Practices
- Department of Veterans Affairs Efforts to Assure That Psychiatric Patients Receive Quality Care
- Department of Veterans Affairs Health Care Services for Women Veterans
- Department of Veterans Affairs Life Insurance Administration Costs
- Department of Veterans Affairs Life Insurance Program Management

Department of Veterans Affairs Medical Centers' Management of Scarce Medical Specialist Contracts
 Department of Veterans Affairs Patient Treatment File Data
 Department of Veterans Affairs Payments to Private Physicians for Veterans' Out-patient Care
 Department of Veterans Affairs Pension Beneficiaries Receiving Medicaid-Covered Nursing Home Care
 Department of Veterans Affairs Prescription Drug Refill Policies, Procedures, and Practices
 Department of Veterans Affairs (VA) Quality Assurance and Joint Commission on Accreditation of Healthcare Organizations' Standards: Noncompliance at VA and Non-VA Hospitals
 Department of Veterans Affairs Rehabilitation Program
 Department of Veterans Affairs Rehabilitation Service for the Severely Disabled
 Department of Veterans Affairs Use of Part-Time Physicians in Its Health Care System
 Effect of State-Mandated Health Insurance Programs on the Demand for Department of Veterans Affairs Services
 Health Care Services Available to Veterans at Department of Veterans Affairs Medical Centers
 Impact of GAO Recommendations on Department of Veterans Affairs Quality Assurance Program
 Management of the Department of Veterans Affairs: Human Resource Management Vital to Success of the Secretary's Strategic Management Process
 Medical Equipment Failures at Department of Veterans Affairs Medical Centers
 Need for a Department of Veterans Affairs Hospital in Hawaii
 Potential Copayments for Department of Veterans Affairs Long-Term Care
 Secretarial-Level Oversight of the Department of Veterans Affairs Programs and Administrative Activities
 The Effect of the Availability of Support on the Quality of Care Furnished by Department of Veterans Affairs Nurses Working in Acute Care Settings
 The Effectiveness of the Department of Veterans Affairs Implementation of Section 8051 of the Omnibus Budget Reconciliation Act of 1990
 Veterans' Federal Health Care Benefits
 Veterans Receiving Either Department of Veterans Affairs Compensation or Military Retirement Disability Benefits
 Waiting Times for Veterans Using Department of Veterans Affairs Medical Centers

OTHER

Assessment of Whether Statutory Amendments to Block Grants Have Constrained States' Flexibility
 Comparability of the Department of Defense's Mental Health Benefits With Other Health Programs
 Comparison of the Operations and Results of the Trade Adjustment Assistance and Economic Dislocation and Worker Adjustment Assistance Programs
 Equal Employment Opportunity Commission Administration of the Age Discrimination in Employment Act
 Opportunities to Increase the Department of Defense's Early Retirement

APPENDIX V—GAO ACTIVITIES REGARDING OLDER WORKERS

GAO appointed 901 persons to permanent and temporary positions during fiscal year 1991, of whom 222 (24 percent) were age 40 and older. Of GAO's total work force of 5,619 on September 30, 1991, 3,176 (56 percent) were age 40 and older.

GAO employment policies prohibit discrimination based on age. GAO's Civil Rights Office continues to (1) provide information and advice and (2) process complaints involving allegations of age discrimination.

GAO continues to provide individual counseling and preretirement seminars for employees nearing retirement. The counseling and seminars are intended to assist employees in:

- calculating retirement income available through the Civil Service and Social Security systems and understanding options involving age, grade, and years of service;
- understanding health insurance and survivor benefit plans;
- acquiring information helpful in planning a realistic budget based on income, tax obligations, and benefits, and making decisions concerning legal matters;
- gaining insights and perspectives concerning adjustments to retirement;

- increasing awareness of community resources that deal with preretirement planning, second career opportunities, and financial planning; and
- increasing awareness of lifestyle options available during the transition from work to retirement.

APPENDIX VI—MAJOR CONTRIBUTORS TO THIS REPORT

HUMAN RESOURCES DIVISION, WASHINGTON, D.C.

Cynthia A. Bascetta, Assistant Director, (202) 275-0020
 James C. Musselwhite, Advisor
 Benjamin C. Ross, Evaluator-in-Charge
 Andrew D. Eschtruth, Evaluator

ITEM 22. LEGAL SERVICES CORPORATION

LEGAL SERVICES CORPORATION ADDRESSING OLDER AMERICANS' LEGAL NEEDS

The Legal Services Corporation (LSC) was created by Congress in 1974, to provide legal assistance to indigent persons in civil matters. LSC annually awards grants to 323 legal services programs in each of the 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, Micronesia, and Guam. These programs employ advocates (attorneys and paralegals) to provide legal assistance to the poor. Each legal services program follows certain guidelines as to the types of cases it accepts and the financial eligibility of possible clients.

For fiscal year 1991, Congress appropriated \$328 million, to LSC. The offices of the regularly funded LSC grantees are staffed by over 6,500 qualified advocates. During calendar year 1990, these legal services advocates closed approximately 1.4 million cases; approximately 13 percent of these cases involved service provision to clients over age 60.

While LSC remains the source of the greatest percentage of funding for most of these legal services programs, other public and private funding sources contributed significant resources. These additional income sources provided over \$180 million to LSC grantees during 1990. Of this amount, over \$12 million was provided by the Federal Government, through the Older Americans Act, for services to senior citizens. Funding from other public and private sources continue to increase each year, with Interest on Lawyers' Trust Accounts (IOLTA) funding leading the way in growth, providing over \$55 million to these legal services programs.

Three of LSC's regular grantees, the National Senior Citizens Law Center, Legal Counsel for the Elderly, and Legal Services for New York City, through its State support provider, Legal Services for the Elderly, focus on legal assistance for older Americans. In addition, some of the law school clinics awarded one-time grants, through the annual Law School Civil Clinical Program grant competition, concentrate on legal services to older Americans.

1. NATIONAL SENIOR CITIZENS LAW CENTER

(Main Office)

1052 West 6th Street Suite 700 Los Angeles, CA 90017 (213) 482-3550

(Branch Office)

2025 M Street, Northwest Suite 400 Washington, D.C. 20036 (202) 887-5280

The National Senior Citizens Law Center (NSCLC), a national support center, was awarded a \$589,512 LSC grant in fiscal year 1991. Under the terms of its grant, the NSCLC provides a variety of services to its national service area, including legislative and administrative representation to the elderly poor. The Center also provides training for attorneys and paralegals, on such topics as age discrimination, Medicaid, Medicare, long-term disability, the Older American Act, pensions, Social Security/SSI, and disability. In addition to producing and distributing the *Washington Weekly* and the *Nursing Home Law Letter*, the Center processed approximately 1,525 requests for assistance regarding elderly issues in calendar year 1990. The Center's Executive Director, Burton D. Fretz, can be contacted for further information.

2. LEGAL COUNSEL FOR THE ELDERLY

601 E Street, Northwest 14th Floor Washington, D.C. 20049 (202) 434-2120

Legal Counsel for the Elderly (LCE) was awarded a \$107,012 LSC supplemental field grant in fiscal year 1991. During calendar year 1990, LCE processed over 1,000 requests for assistance from elderly clients, in such general areas as public benefits protection, protective services, consumer and probate. In addition, LCE, in conjunction with the American Association for Retired Persons (AARP), provides specific outreach to the homebound and the Hispanic communities of Washington, D.C. The Program's Executive Director, Wayne Moore, can be contacted for further information.

3. LEGAL SERVICES FOR NEW YORK CITY

(Legal Services for the Elderly—Branch Office)
130 West 42nd Street
17th Floor,
New York, New York 10036
(212) 391-0120

Legal Services for New York City (LSNY), was awarded a \$13,060,324 basic field grant for fiscal year 1991. Additionally, LSNY received \$120,584 in State support funds. A small portion of those State support funds was given to one of LSNY's branch offices, Legal Services for the Elderly, which provides State support services.

In calendar year 1990, Legal Services for the Elderly processed approximately 248 requests for legal assistance on such elderly issues, which included age discrimination, Social Security, and SSI. LSNY's Executive Director, Dale S. Johnson, can be contacted for further information.

LAW SCHOOL CIVIL CLINICAL PROGRAM

LSC also provides funding for law school clinics. Because such grants are made on an academic year basis, services to elderly Americans were provided by these grants from two separate grant cycles—1990-91 and 1991-92.

For the academic year 1990-91, LSC awarded grants to a total of 20 law school clinics, two of which concentrated on elderly issues.

1. SOUTHERN ILLINOIS UNIVERSITY AT CARBONDALE SCHOOL OF LAW

Southern Illinois University received \$64,093 to continue its Legal Clinic, which provides legal services to low-income persons, over the age of 60, in 13 southern counties of Illinois. Such legal assistance is provided in the following areas: drafting wills, durable power of attorney, living wills, elderly abuse, and financial exploitation of the elderly. During the 12-month grant period, the clinic served over 3,568 elderly persons and closed 1,647 cases.

2. UNIVERSITY OF INDIANA/INDIANAPOLIS SCHOOL OF LAW

The University of Indiana received \$68,546 to continue its clinical legal services in representing indigent, ill, and elderly clients, who are HIV-infected or who suffer from other long-term illnesses, such as AIDS and Alzheimer's disease. During the 12-month grant period, the clinic served over 613 individuals and closed 245 cases.

For the academic year 1991-92, LSC awarded \$1,183,531 to a total of 20 law school clinics. While each of these schools will assist elderly clients on an as needed basis, the following four law schools concentrate specifically on elderly issues.

1. UNIVERSITY OF WISCONSIN SCHOOL OF LAW

The University of Wisconsin received \$57,000 to provide direct legal assistance to low-income, elderly individuals on housing issues, including government-funded housing, group homes, and nursing homes. Clinic Director: Louise G. Trubek.

2. SOUTHERN ILLINOIS UNIVERSITY AT CARBONDALE SCHOOL OF LAW

Southern Illinois received \$68,799 to continue its Legal Clinic's provision of legal services to low-income elderly persons in 13 southern counties of Illinois, on such issues as drafting wills, durable power of attorney, living wills, elderly abuse, and financial exploitation of the elderly. Clinic Director: Mary Rudasill.

3. YESHIVA UNIVERSITY/BENJAMIN N. CARDOZO SCHOOL OF LAW

Yeshiva University received \$59,524 to provide legal assistance to low-income elderly and disabled individuals with problems in receiving government benefits, particularly health benefits, under Medicare and Medicaid. Clinic Director: Toby Golick.

4. UNIVERSITY OF INDIANA/INDIANAPOLIS SCHOOL OF LAW

The University of Indiana/Indianapolis received \$52,960 to continue the provision of legal assistance to low-income, ill, and elderly individuals who are HIV-infected or who suffer from other long-term illnesses, such as AIDS and Alzheimer's disease. Clinic Director: William E. Marsh.

ITEM 23. NATIONAL ENDOWMENT FOR THE ARTS

DECEMBER 17, 1991.

DEAR MR. CHAIRMAN: I am pleased to report to you on the fiscal year 1991 activities of the National Endowment for the Arts involving older Americans.

During this period, the Endowment supported a variety of efforts that strengthen links between the arts and older citizens. Of particular note is a new Working Group on Older and Disabled Americans that I established to stimulate a coordinated Endowmentwide focus on issues and initiatives involving older and disabled people.

Further, we are working with AARP, the Leadership Council on Aging (comprised of 33 key national groups on aging), as well as with staff from the White House Conference on Aging to explore potential partnership activities. In particular, we are working with the White House Conference on Aging to ensure that cultural activities are addressed as part of the 1993 conference. We will keep you apprised of future developments.

The report which follows provides a thorough description of our program, technical assistance, and funding activities in support of increased access to the arts for older individuals.

I am grateful for the opportunity to provide you and members of the Special Committee on Aging with this update of our work.

Sincerely,

JOHN E. FROHNMEYER, *Chairman*.

Enclosure.

THE NATIONAL ENDOWMENT FOR THE ARTS SUMMARY OF ACTIVITIES
RELATING TO OLDER AMERICANS—FISCAL YEAR 1991

INTRODUCTION

As part of our overall mission, the Endowment encourages greater access to and participation in the art in the belief that exposure to artistic experiences contributes to the quality of life for all citizens. Through grants awarded to individuals and organizations, as well as its own programming, the Arts Endowment ensures the continued involvement of older adults as creative artists, students, volunteers, audience members, and patrons.

The arts help us express some of our deepest feelings—of love, trust, alienation, and hope. Art teaches us to verify our most personal experiences, to listen to intuition along with reason, and to perceive what is beyond the obvious. To develop in each person a sense of worth, of self-esteem through self-expression in the arts, is a task which we Americans—young and old, black and white, rich and poor—face together as we near the beginning of a new century and a new age.

Audiences, likewise, are not bound by age. In concert halls, museums, opera houses, jazz clubs, and other venues, you are likely to find a significant portion of the audience composed of older Americans who bring experience, appreciation, and understanding of the rich complexities of the arts.

OFFICE FOR SPECIAL CONSTITUENCIES

The Office for Special Constituencies serves as the technical assistance and informational arm of the Arts Endowment for people who are older, disabled, or living in health care institutions. This office works in a myriad of ways to assist the Endowment and its grantees in making the arts available to these often underserved citizens. Established by the National Council on the Art in 1976, the office develops a broad range of cooperative efforts with Endowment programs and grantees, organizations representing special constituencies, and other Federal agencies to further the Endowment's access goals. Many of these initiatives are described in this report.

WORKING IN PARTNERSHIP WITH OTHERS

WHITE HOUSE CONFERENCE ON AGING

On June 3, 1991, President Bush announced his intention to call a White House Conference on Aging to be held in 1993. The conference theme will be "A Bonding of Generations" and will provide an opportunity for a broad spectrum of Americans to come together to discuss the needs of older citizens. The Endowment is working with the Leadership Council on Aging, comprised of 33 national groups on aging, to explore partnership between the Endowment and aging groups to ensure that cultural activities are on the agenda of this conference. We have also met with key officials of the American Association of Retired Persons and exchanged ideas on a number of ways in which the Endowment may work with AARP and other aging groups to reach their constituents.

NEA WORKING GROUP ON OLDER AND DISABLED AMERICANS

During this reporting period, the Chairman established an Endowment Working Group on Older and Disabled Americans to make access issues an even greater priority and to facilitate a more integrated approach throughout the Endowment on issues involving these individuals. The group is chaired by Anne-Imelda Radice, Senior Deputy Chairman; coordinated by Paula Terry who heads the Special Constituencies Office; and includes staff from each Endowment Program. Among the issues being addressed by the working group are ways to increase the recognition of older artists and highlight model programs that focus on older people.

UNIVERSAL DESIGN: DESIGNING FOR THE LIFESPAN

A major focus of our aging work has been in the area of design. We are addressing issues fundamental to the needs of older people and those with disabilities who often face barriers in the built environment, including their own houses as well as in public institutions.

In response to these issues, the Endowment has undertaken a Universal Design leadership initiative to educate designers, city officials, and planners, schools of design, and others involved in the design process concerning all aspects of designing the total human environment for the full lifespan. Integrating access accommodations into design is the most economical and sensible approach to complying with Federal laws including the Fair Housing Amendments Act of 1988 and the 1990 Americans with Disabilities Act that President Bush signed into law on July 26, 1990.

As indicated in the Endowment's previous activities report, the Special Constituencies Office and the Design Arts Program consulted with 13 leading practitioners and advocates of universal design to determine how the Endowment might better serve and educate the field on this important concept. As a result, we have allocated \$185,000 of FY 1991-92 funds to implement two of their priority recommendations for a universal design video and touring exhibition.

The video will be an introduction to universal design, suitable for use in professional schools of design, secondary schools, conferences, and other public forums. It will demonstrate how poorly designed environments and products actually disable people by making their lives difficult and stigmatizing them. In contrast, the video will show how the application of universal design enhances accessibility and the activities of all people, regardless of their age or level of abilities, leading to a more integrated, inclusive, and humane world.

The exhibition will introduce the concept of designing for the lifespan and feature high quality examples drawn from the design fields. Anticipated venues for the exhibit include the annual meetings of design professionals and organizations that represent older people, trade shows, and other sites.

REGIONAL ACCESS SYMPOSIUM

State arts agencies and other arts service organizations need direct assistance in making their activities more accessible and in educating their constituents on how to make programs more available to older adults and people with disabilities. In response to this need, the Special Constituencies Office is working with regional arts organizations to convene access symposia for arts administrators. The first conference, *Access to the Arts: A Right, Not A Privilege*, took place in Washington, DC on July 9-10, 1990. Co-sponsored by the Mid-Atlantic Arts Foundation, this highly successful effort brought together 260 arts administrators who addressed a broad range of access issues. Presently, the Special Constituencies office is working with the

Southern Arts Federation in Atlanta to plan a similar effort, for their nine state region, that will take place in October 1992.

MUSEUM GUIDE ON ACCESSIBLE PROGRAMMING

The Special Constituencies Office is working with the Institute of Museum Services and the American Association of Museums (AAM) to produce the first museum access guide. This publication will feature exemplary museum programs across the country accessible to older people and those with disabilities. The AAM has completed 10 of the 20 case studies that will be highlighted in the book and will begin marketing this first-time book in the fall of 1992.

SUMMARY OF NATIONAL ENDOWMENT FOR THE ARTS PROGRAM ACTIVITIES AFFECTING OLDER AMERICANS

The Endowment continues its program activities in support of projects involving older people. Since people of all ages benefit from most Endowment grants, it is difficult to estimate the total number of Endowment-supported programs that serve older Americans. However, many Endowment grants do support arts activities specifically organized to include older people.

Examples of Endowment-supported efforts that benefit older people are listed by arts discipline.

DESIGN ARTS

San Francisco State University, in San Francisco, CA, is supporting a research project to explore the design of public landscapes accessible to all people. "Landscapes for All" plans to go beyond basic entry needs by developing and testing prototypical designs that are both accessible and usable for older Americans and individuals with disabilities. The design will include access to large turf areas; tactile and graphic signage, outdoor furniture designs, and layouts; trail and path examples; garden design for close contact; access to sand and water areas; and other recreational needs.

Alternative Worksite/Bemis Foundation, in Omaha, NE, is researching barrier-free design to convert and renovate an industrial warehouse into an arts alternative worksite. The new facilities will include studios, exhibition spaces, living areas, offices, and a library for people of all ages.

Design Access, in Washington, DC, at the National Building Museum, is developing a 10-15 minute Universal Design video tape, portable exhibit, and accompanying brochure on designing for the lifespan. This Universal Design project provides information on exemplary accessible design to design students, professionals in practice, and other audiences. The project will provide documented challenges faced by people with visual, mobility, and other impairments when using products, buildings, and public spaces. It will feature professionals, developers, and manufacturers who have integrated this approach into their work.

Adaptive Environments Center, in Boston, MA, is working with the Center for Accessible Housing and universal design experts to teach universal design principles to design schools through their faculty. Two conferences will provide faculty members with technical assistance and support and promote a national network on universal design.

Edward H. Steinfeld, from Buffalo, NY, is developing a book on universal design, examining its potential contribution to social equality. Universal design goes beyond "special" features and elements—it is design process that incorporates features, elements, and products that may, to the greatest extent possible, be used by everyone. It accommodates people of all ages, sizes, and abilities.

EXPANSION ARTS

Brandywine Graphic Workshop, Inc., in Philadelphia, PA, is supporting a new residencies program that includes eight older printmakers who serve as visiting artists and lecturers. Each artist will provide 10 days of instructional workshop time.

Bronx Museum of the Arts, Inc. in Bronx, NY, plans to mount 22 shows emphasizing exhibition opportunities for culturally diverse artists. The works will be displayed at sites including Beth Abraham Hospital, Jewish Home for the Aged, Hebrew Hospital for Chronic Sick, and Narco-Freedom Methadone Clinic. The museum will continue to explore the possibility of new sites in areas presently not receiving service. The exhibitions are enhanced with educational outreach programs involving workshops and discussions with the artists.

Catamount Film and Arts Company/G.R.A.C.E., in St. Johnsbury, VT, offers an exhibit program where artist Don Senseri assists in development of visual art projects created by older Americans in rural Vermont. The development of this work is accomplished through weekly workshops in nursing homes, community centers, and a special workshop.

Afrikan Poetry Theatre, Inc., in Jamaica, NY, presents "Tribute to an Elder", a tribute to a well known black writer who has been professionally active for many years.

Senior Arts, Inc., in Albuquerque, NM, provides a series of 17 workshops and 47 performances by local artists featuring traditional New Mexican folk as well as contemporary music, dance, theater, visual arts, and literature. Local artists will be sharing their skills with over 3,000 older Americans participating in the workshops.

FOLK ARTS

National Heritage Fellowships were awarded to 11 folk artists age 65 and older whose works exhibit authenticity, excellence, and significance within a particular tradition.

Etta Baker, African-American guitarist, from Morgantown, NC

Jack Coen, Irish-American flautist, from Bronx, NY

Eduardo Guererro, Mexican-American singer/guitarist/composer, from Cathedral City, CA

Donald L. King, Western saddle-maker, from Sheridan, WY

Riley "B.B." King, African-American bluesman, from Itta Bena, MS and Las Vegas, NV

Esther Littlefield (Aanwoogeex), Alaskan regalia maker (Tlingit), from Sitka, AK

Seisho "Harry" Nakasone, Okinawan-American musician, from Honolulu, HI

Morgan Sexton, Appalachian banjo player/singer, from Linefork, KY

Nikitas Tsimouris, Greek-American musician (bagpipe player), from Tarpon Springs, FL

Gussie Wells, African-American Quilt-maker, from Oakland, CA

Arbie Williams, African-American Quilt-maker, from Oakland, CA

Elders Share the Arts, Inc., in Brooklyn, NY, presents performances by elder storytellers from diverse cultural backgrounds. The storytellers perform their narratives in six community centers of the five boroughs of New York City. ESTA's older adult storytelling group, "Pearls of Wisdom", has discovered a number of gifted storytellers, each with a great ability to tell authentic tales of triumph and courage. Storytellers from African-American, Latin, and Caribbean heritage are represented.

La Compania de Teatro de Albuquerque, in Albuquerque, NM, presents traditional New Mexican music and songs to older Americans at 5 nursing centers and 10 meal sites. Approximately 23,000 older adults have enjoyed these narrative musical presentations.

Institute for Italian American Studies, Inc., in Jamaica Estates, NY, provides performances at centers for older adults throughout New York. Local Italian-American musicians, dancers, and masquers perform their traditional art forms from Montemarano, Italy.

Metropolitan Library Commission of Oklahoma County, in Oklahoma City, sponsors "A Celebration of Tradition", a crafts and performing arts event featuring older master traditional artists. This project will be presented to audiences of older adults across the State.

INTERNATIONAL ACTIVITIES

African American Dance Ensemble, in Durham, NC, is interviewing village elder dancers of Gambia and Zimbabwe to develop a video documenting dance styles. The long-term goal is to develop archival material to be made available to institutions and libraries.

LITERATURE

Senior Fellowships were awarded to writers age 65 and older "who have made an extraordinary contribution to American literature over a lifetime of creative work." These artists are:

William Stafford, writer/poet, from Hutchinson, Kansas

Margaret Walker, writer from Jackson, Mississippi

The Guild Complex, in Chicago, IL, is providing contemporary literature and mixed media presentations to older Americans at the Guild Complex. They will reach out to older citizens through the Chicago Department on Aging and the Chicago Housing Authority Literacy Initiative.

The Community Writers' Project, Inc., in Syracuse, NY, produces anthologies of literary work by older Americans participating in their workshops.

MEDIA ARTS

Paul Wagner, from Washington, DC, is creating a documentary featuring the stories of six older people from diverse backgrounds.

Bob Ruck, from Pittsburgh, PA, is creating a documentary about "Pittsburgh's Old Negro League."

Washington, DC International Film Festival, offers "Cinema for Seniors" a program designed to present free international films to older people. Annual film festivals are held in collaboration with the Library of Congress, the American Film Institute, the Smithsonian Institution, the National Archives, the Black Film Institute, and the major Washington theater owners in order to bring the best of world cinema to the nation's capitol.

International Museum of Photography at George Eastman House, in Rochester, NY, provides a matinee program for older Americans that features American, Latin-American, other foreign classics, and silent films with full orchestral accompaniment.

MUSEUM

Hudson River Museum, in Yonkers, NY, is expanding their docent training program, emphasizing the needs of older persons and those with disabilities. They are also making two permanent exhibitions accessible to visually impaired audiences by implementing a touch collection and scale models.

Metropolitan Museum of Art, in New York City, is preparing the first manual on accessible labeling for museum signage and labels that will address the needs of those with visual impairments. The standards will be based on guidelines published by a variety of national organizations as well as input from museum staff and consultants.

MUSIC

Arioso Wind Quintet, in San Diego, CA, provides chamber music concerts to Miguel Covenant Village (a community for older Americans).

Long Island Baroque Ensemble, Inc., in Locust Valley, NY, is bringing their chamber music to older Americans in Long Island nursing homes and hospitals.

Maelstrom Percussion Ensemble, in Buffalo, NY, is performing its annual concert series at Rockwell Hall Auditorium at Buffalo State College. The concerts feature the finest new music for percussion. Outreach efforts include 40 performances at centers for older Americans.

Rosewood Chamber Ensemble, Inc., in Sunnyside, NY, is bringing chamber music and lecture/demonstrations to centers for older Americans. This music highlights contemporary American composers.

Sea Cliff Chamber Players, Inc., in Sea Cliff, NY, has a program designed to offer high quality music at reduced ticket prices to older Americans.

Young Concert Artists, Inc./Hexagon, in New York, NY, includes centers for older Americans, nursing homes, and hospitals in their chamber music concert tour season.

Canton Symphony Orchestra Association, in Canton, OH, presents lecture/demonstrations, performance recitals, and concerts in nursing homes and centers for older Americans.

Evansville Philharmonic Orchestra, in Evansville, IN, performs nearly 60 concerts yearly at older adult centers and State hospitals. They also sponsor a bus with free shuttle service to and from their concerts.

Pro Musicis Foundation, in New York, is bringing soloist recitals to institutionalized audiences of the Boston, New York, Los Angeles, and District of Columbia areas during their four city promotional concert tour.

Lexington Philharmonic Society, in Lexington, KY, gives concerts in retirement homes, hospitals, and institutions in Kentucky.

Lincoln Symphony Orchestra Association, in Lincoln, NE, provides transportation to the concert hall for low-income older Americans.

Tulsa Philharmonic, in Tulsa, OK, has a program called "Ensembles in Institutions" that provides performances of string quartets, woodwind quintet, and brass quintet to people in institutions who cannot attend their regular concerts. In the 1990-91 season, 30 concerts were given in institutions for approximately 1500 people.

Flint Institution of Music, in Flint, MI, performs Sunday matinee concerts targeted to families and older Americans. Programs include American works.

Fort Wayne Philharmonic Orchestra, in Fort Wayne, IN, has a core group of 18 musicians that perform chamber orchestra and ensemble concerts in centers for older Americans.

Santa Barbara Symphony Orchestra Association, in Santa Barbara, CA, offers discounted symphony orchestra tickets to older Americans.

Stamford Symphony Orchestra, Inc., in Stamford, CT, offers discounted and free tickets to older Americans.

New England Foundation for the Arts, in Cambridge, MA, has an outreach program for older Americans to present New England-based chamber and new music ensembles, choruses, jazz ensembles, and six Young Concert Artists performances.

Quad City Arts, in Davenport, IA, conducts a residency program in 40 hospitals and continuing care facilities. The residencies are a combination of performance and discussion. At the end of the residency, a full public concert is presented free of charge in one of several local theaters. In 1990-91, Visiting Artists presented 276 performances by 24 nationally recognized artists throughout the greater Quad City region, reaching an estimated 80,000 people.

VISUAL ARTS

Expoloratorium, in San Francisco, CA, is commissioning a sculptor to create and install a series of works in the museum to function as an orientation and navigation system for people with visual impairments. The works consist of tactile maps in bronze surrounded by special floor textures that direct people to the maps.

Snug Harbor Cultural Center, in Staten Island, NY, conducts a series of residencies in which artists work with older Americans to create new work for installation in the Snug Harbor galleries.

ITEM 24. NATIONAL ENDOWMENT FOR THE HUMANITIES

DECEMBER 13, 1991.

DEAR SENATOR PRYOR: I am pleased to enclose a report summarizing the major activities for or about the aging supported by the National Endowment for the Humanities in fiscal year 1991.

Many of the projects that received Endowment support during the past year either involved older Americans as grant recipients or project contributors or were of particular interest to them. Several also specifically addressed older persons as an audience or aging as an issue. But the potential of NEH for older Americans does not stop there. The products resulting from all Endowment programs are available to older Americans for their personal enjoyment and enrichment—from the books and articles written by humanities scholars to the film and radio programs and reading and discussion groups supported by our Public Programs division.

The State humanities councils have also been very active in developing programs for or about the aging, and a number of their efforts are summarized in the report. Anyone wishing further information on the State councils' activities in this area is invited to contact NEH or any one of the councils.

I hope that you and your Committee will find this material useful. Please let me know if we can be of any further assistance.

Sincerely,

LYNNE V. CHENEY,
Chairman.

Enclosure.

NATIONAL ENDOWMENT FOR THE HUMANITIES REPORT ON ACTIVITIES AFFECTING OLDER AMERICANS IN 1991

I. THE MISSION OF THE ENDOWMENT

The National Endowment for the Humanities was established by Congress to support the advancement and dissemination of knowledge in history, literature, philosophy, and other disciplines of the humanities. NEH grants sponsor scholarship and research, promote improvements in education, and foster greater public understanding and appreciation of our cultural heritage. Grants are awarded in response to unsolicited project proposals and on the basis of evaluative judgments informed by a rigorous process of review. The agency does not set aside fixed sums of money for work in any discipline or for any particular area of the country or group. As a result, there is no grant program at NEH specifically for senior citizens, nor is there

a funding category within the agency expressly designed to support the study of aging or the elderly. Rather, projects for or about senior citizens may receive support through the full range of Endowment programs.

Although the Endowment does not have programs specifically related to aging, NEH-supported books, lectures, exhibitions, productions for radio and television, and library reading and discussion programs help bring the humanities to senior citizens. In addition, each year a number of scholars who are 65 years of age or older receive NEH funding to conduct research in the humanities or present educational programs for the general public, while others assist the Endowment by serving on grant review panels or as expert evaluators.

II. PARTICIPATION BY OLDER AMERICANS IN NEH PROGRAMS

Older scholars compete for Endowment support on the same basis as all other similarly qualified applicants. Applications for funding are evaluated by peer panels and specialist reviewers, Endowment staff, the National Council for the Humanities, and the NEH Chairman. Only applicants whose proposals are judged likely to result in work of exemplary quality and central significance to the humanities receive support. However, anyone may apply for an NEH grant, and no one is barred from consideration because of age. Each year numerous projects are funded that involve older persons as primary investigators, project personnel, or consultants.

The Jefferson Lecture in the Humanities is the highest official award the Federal Government bestows for distinguished intellectual achievement in the humanities. Since its establishment in 1972, the lecture has provided an opportunity for 21 of the Nation's most highly regarded scholars to explore in a public forum matters of broad concern in the humanities. Not coincidentally, many of the scholars so honored have been among the most senior members of their profession. Classicist Bernard Knox, who will deliver the 1992 Jefferson Lecture, historians Gertrude Himmelfarb and Bernard Lewis, novelist Walker Percy, sociologist Robert Nisbet, and literary scholar Cleanth Brooks are among the recent Jefferson Lecturers who, though still active scholars, were beyond the traditional retirement age at the time they received this honor.

The Endowment's Charles Frankel Prize, first awarded in 1989, honors distinguished individuals who have enriched our national life by sharing their understanding and appreciation of history, literature, philosophy, and other aspects of the humanities. To date, 7 of the 15 interpreters and patrons of the humanities who have received a Frankel Prize have been 65 years of age or older. They are: Winton Blount, philanthropist and builder of the Alabama Shakespeare Festival's Carolyn Blount Theatre; Louise Cowan, University of Dallas English professor emeritus and cofounder of the Dallas Institute of Humanities and Culture, which is helping teachers use literature to teach values; Daniel Boorstin, Librarian of Congress Emeritus and historian; author and folklorist Americo Paredes; Mortimer Adler, philosopher, prolific author, and originator of the Great Books program; classicist and 1992 Jefferson Lecturer Bernard Knox; and Ethyle Wolfe, originator of Brooklyn College's highly regarded core curriculum.

Older scholars are particularly evident in several types of research and teaching projects supported by the Endowment's Fellowships and Seminars division and Research Programs division. Of course, this is merely a reflection of the depth and breadth of knowledge that many senior scholars bring to their work in the humanities. In a number of cases, older scholars are receiving NEH support to continue long-term, collaborative research projects that they have directed and sustained for many years. In FY 1991, NEH support for the research and teaching efforts of scholars, 65 or older, included the awarding of 5 Fellowships for University Teachers totalling \$123,164, 8 grants totalling \$696,332 to direct Summer Seminars, 13 grants totalling \$793,492 to produce scholarly editions, 7 grants totalling \$507,896 to translate important foreign language works; 5 grants totalling \$254,700 to conduct major interpretive research projects, and 8 grants totalling \$795,653 to produce research tools and reference works. Among the eminent older scholars whose containing contributions to the humanities were underwritten by the Endowment during FY 1991 were:

- Alan Gewirth of the University of Chicago, who will complete a work of philosophy entitled *The Community of Rights* in which he argues that the moral principle of individual rights entails a communitarian conception of human relationships;
- Philip Curtin of Johns Hopkins University, who directed a Summer Seminar for University Teachers on the Atlantic plantation system, 1450-1890;

- Irma Lustig of the University of Pennsylvania, who will direct a Summer Seminar for School Teachers on James Boswell's *Journal* and *The Life of Samuel Johnson*;
- Frederick Burkhardt, who, under the auspices of the American Council of Learned Societies, is preparing an edition of the correspondence of Charles Darwin;
- Richard Showman, who, in conjunction with the Rhode Island Historical Society, is preparing an edition of the papers of revolutionary war general Nathaniel Greene;
- David Underdown of Yale University, who is preparing an edition of the documentary sources that record the proceedings of the English Parliament of 1626 and the opening session of the Long Parliament;
- Philip Kolb of the University of Illinois, Urbana, who is translating selected letters of Marcel Proust in order to produce an edition of the novelist's correspondence;
- 1976 Jefferson Lecturer John Hope Franklin, who is writing a book on runaway slaves;
- Ehsan Yarshater of Columbia University, who is directing work on the *Encyclopedia Iranica*, which covers all aspects of the history and culture of the Iranian peoples;
- Frederick Cassidy of the University of Wisconsin, Madison, who is producing volume 3 of the *Dictionary of American Regional English*; and
- Ake Sjoberg of the University of Pennsylvania, who is directing a long-term project to complete the Pennsylvania Sumerian Dictionary, a multi-volume lexicon of the oldest known written language.

Older Americans also participated in NEH programs by serving as grant review panelists, specialist reviewers, or members of special advisory groups. Edmund Pincoffs, professor of philosophy at the University of Texas, Austin; Milton Klein, emeritus professor of history at the University of Tennessee, Knoxville; Beatrice Patt, dean emeritus at Sweet Briar College in Virginia; Helen Tanner, independent scholar and editor of the *Atlas of Great Lakes Indian History*; R.W.B. Lewis, professor of American studies at Yale University; and Helen North, emeritus professor of classics at Swarthmore College are among the senior scholars who contributed their time and talent in this way during FY 1991.

In some cases, older Americans without scholarly training have contributed to Endowment-sponsored projects by providing invaluable information. For example, several NEH-supported projects to document or preserve the unique cultures of Native American peoples are heavily indebted to older tribal members for their, in many cases, irreplaceable resources of memory and understanding. In FY 1991, the Endowment awarded \$54,211 in support of a long-term linguistic project in which a panel of tribal elders is helping scholars at the University of Arizona compile a dictionary of the Hopi language. Researchers from the University of Hawaii received additional NEH support of \$10,000 to continue fieldwork, including interviews with elderly native speakers, that will enable them to complete an NEH-sponsored dictionary of the Thomson River dialect of Salish, a native American language family of the Pacific Northwest. Elderly Spanish speaking informants are also contributing to research in the humanities. In FY 1991, scholars at the University of New Mexico received an NEH grant of \$225,000 to produce a linguistic atlas and archive of the Spanish of New Mexico and Southern Colorado. The project team will interview 350-400 Spanish speakers, many of them elderly persons fluent in the traditional dialect of the region.

Of course, the Endowment achieves its greatest impact among older Americans when they read books, attend public programs, view television productions, or listen to radio broadcasts made possible by an NEH grant. Many humanities programs for the general public supported by the Endowment through our Division of Public Programs reach large numbers of older persons.

Humanities Projects in Media. Television productions supported by the Endowment are ideal for older people who cannot or prefer not to leave their homes. Widely acclaimed programs such as the 11-hour historical documentary series, *The Civil War*; the series of dramatic literary adaptations, *American Short Story and Life on the Mississippi*; the biographical documentary, *Huey Long*; and *Voices and Visions*, a 13-part series chronicling the achievements of America's outstanding contemporary poets, have been viewed by millions throughout the country. NEH-funded programs broadcast recently include *Columbus and the Age of Discovery*, the seven-part historical dramatization that led off PBS's fall schedule, and two historical documentaries of particular interest to older Americans, *Pearl Harbor: Surprise and Remembrance* and *Duke Ellington: Reminiscing in Tempo*.

Elderly persons who have visual handicaps may find Endowment-sponsored radio programs best suit their needs. For example, the Endowment supported National Public Radio's fall, 1990 broadcast of eight, 30-minute radio programs examining the career of New York Mayor Fiorello La Guardia and the history of that city during the 1930's and 1940's. *Tell Me A Story*, NPR's long-running series of half-hour programs in which major contemporary authors read from their short stories and comment on the creative process, and *Old Traditions—New Sounds* 13, 30-minute programs that examined the immigrant experience and the surviving cultural heritage of first- and second-generation American musicians, are two more examples of engaging radio programs that have aired recently with Endowment support.

Information about NEH-sponsored media programs is routinely provided to organizations working for special groups, including the elderly. For many elderly people confronting problems such as impaired vision, reduced mobility, and isolation, Endowment-funded media programs not only provide individual access to the humanities but can also provide the context for stimulating group activities and discussions.

Humanities Projects in Museums and Historical Organizations. In this program, the Endowment encourages museums or historical organizations receiving Federal funding to waive entrance fees for the general public on certain days, an effort that helps make cultural programming more accessible to retired persons living on a fixed income. In recent years, a number of the institutions that have received NEH support for interpretive exhibitions have begun to establish a continuing relationship with local senior centers.

Public Humanities Projects. Grants awarded during FY 1991 in this program are supporting several multifaceted public programs commemorating the 50th anniversary of the Second World War, an occasion certain to be of compelling interest to those Americans old enough to have experienced the period at first hand. The State University of New York, Albany, received \$250,650 to support a variety of public programs, including lectures by noted scholars on such topics as "The Pearl Harbor Controversy;" "Franklin Roosevelt as War Leader;" "War, Women, and Work;" and "The Roots of the Cold War." The University of Alabama received \$151,250 to present a series of 1-day symposia in five Southern States that will examine the personal, domestic, and international impact of World War II on Americans at home and abroad, and the Virginia Historical Society received \$65,450 to support a symposium and a series of monthly discussion programs on Virginia during the war. Both of these projects explicitly incorporate outreach efforts designed to involve veterans groups and organizations representing retired persons.

Humanities Projects in Libraries and Archives. By sponsoring reading and discussion programs for adults in public libraries, this Endowment program is helping to make intellectually stimulating activities available to senior citizens in their local communities. During FY 1991, the Endowment awarded \$1.6 million for programs in 50 States that will offer adults, including persons over 65, opportunities to read and talk about important books and issues, and a great many more reading and discussion programs were supported by the 55 State humanities councils. Two large-scale reading and discussion programs supported by the Endowment—though intended for adults of all ages—will be especially well suited for senior participants. The North Carolina Center for Creative Retirement at the University of North Carolina, Asheville, was awarded \$158,035 to present a series of lectures and book and film discussion programs in four States that will examine railroads as reflected in literature and history, and the Utah Book Group received \$175,000 to support a series of scholar-led reading and discussion groups—many in senior centers in rural areas—that will focus on topics such as South Africa, Native American culture, and the mythology of the American West.

III. EXAMPLES OF NEH GRANTS SPECIFICALLY FOR OR ABOUT OLDER AMERICANS

Since FY 1976, the Endowment has awarded approximately \$3.6 million to the National Council on the Aging for its "Discovery Through the Humanities" program. Throughout a network of over 1,500 senior centers and other sites participating in this project, volunteer leaders guide small groups of senior citizens though active, in-depth discussions of the work of prose writers, poets, artists, philosophers, scholars, and critics. Project staff prepare and distribute thematically organized anthologies and ancillary instructional materials and provide training and technical assistance to discussion leaders. The 16 anthologies currently in use include: "A Family Album, The American Family in Literature," "Images of Aging," "Americans and the Land," "The Remembered Past, 1914-1945," "Work and Life," "The Search for Meaning," and the newly completed "Roll On, River: Rivers in the Lives

of the American People." Each anthology is designed to stimulate the group participants to relate what they read to their own experience and to universal human issues. Ranging between 100 and 300 pages in length, printed in large print-type, and attractively illustrated with paintings, sculpture, and photographs, each anthology contains material from history, philosophy, and literature; both the classics and contemporary authors are represented.

In FY 1991, the National Council on the Aging received \$178,000 to conduct reading and discussion programs in libraries and senior centers in Florida, Oregon, Pennsylvania, and Texas. The theme of these programs will be "The Family in American Cultures," and, rather than read short selections from an anthology as in the NCOA's "Discovery Through the Humanities" series, participants in these programs will read the full texts of literary works (which will be available in Talking Book and large-print formats). In FY 1991, NCOA also received \$19,998 to plan a new reading and discussion series and anthology to be entitled "Remembering World War II."

During the past fiscal year, the Endowment also awarded \$70,650 to the East Tennessee Historical Society for a project specifically intended for senior adults. Entitled "Journey Through Appalachia," this effort will bring scholars into 11 senior centers throughout eastern Tennessee to conduct discussions of books and films related to the history of that region.

IV. STATE PROGRAMS AND THE AGING

The State Programs Division of the Endowment makes grants to humanities councils based in the 50 States, Puerto Rico, the District of Columbia, the Virgin Islands, the Northern Marianas, and Guam. These councils, in turn, competitively award grants for humanities projects to institutions and organizations within each State. State humanities councils have been authorized to support any type of project that is eligible for support from the Endowment, including educational and research projects and conferences. The special emphasis in State programs, however, is to make focused and coherent humanities education possible in places and by methods that are appropriate to adults.

Examples of projects for older Americans or about aging-related topics that received State council support during FY 1991 are presented below.

Arizona

The Arizona Humanities Council provides continuing support for a variety of reading and discussion programs in the State's senior citizen communities.

Arkansas

The Arkansas Humanities Council funded a reading and discussion series entitled "American Families Across Cultures." Senior participants in seven retirement communities explored family relationships as depicted in five novels.

Georgia

The Georgia Humanities Council offers a "Senior Citizens' Literary Program" in which poetry, short stories, essays, songs, and folk tales are the focus of discussions among community college faculty and students and the residents of eight nursing homes in rural, southwest Georgia. Another program, "Creativity and Self-Significance in Aging," is supporting in-depth interviews with older adults that will be the basis of a series of radio and television broadcasts.

Illinois

The Illinois Humanities Council's "Walking Home" project selected material from oral history interviews conducted in conjunction with an earlier project in order to create a collection of vignettes that capture history as seen through the eyes of older members of society.

Indiana

The Indiana Humanities Council supported a film discussion program in two senior centers in the northern part of the State. The two participating scholars chose films such as *Driving Miss Daisy*, *The Color Purple*, and *Bebette's Feast* to raise questions about aging and relationships as depicted in literature and film.

Kansas

The Kansas Committee for the humanities offers a series of packaged programs for older adults, including lectures on U.S. history and slide illustrations of regional folklore, culture, and history.

North Carolina

The North Carolina Humanities Council contributed to a large-scale project that has also received major funding from NEH and will be conducted by the North Carolina Center for Creative Retirement. Six, 8-week-long reading and discussion programs on the history of railroads will be held in each of the four participating States.

New Jersey

The New Jersey Committee for the Humanities supported an intergenerational reading and discussion group of high school students and senior citizens that discussed the varying perspectives of young and old in relation to several contemporary literary works.

ITEM 25. NATIONAL SCIENCE FOUNDATION

NOVEMBER 7, 1991.

DEAR MR. CHAIRMAN: Your letter of October 2, 1991 to the Director of the National Science Foundation (NSF) was referred to the Directorate for Biological, Behavioral, and Social Sciences.

It is a pleasure to report on the activities of NSF related to aging and the concerns of the elderly. As stated in the enclosed report, the Foundation does not have any programs directed specifically toward issues related to aging. However, basic and applied research projects having both direct and indirect bearing on this important area of national concern are supported through the Foundation's regular research grant programs. Most such projects have been supported through the Division Biological and Critical Systems in NSF's Directorate for Engineering, and through the Divisions of Behavioral and Neural Sciences, and Social and Economic Science in the Directorate for Biological, Behavioral, and Social Sciences.

If you would like additional information, please do not hesitate to call on me.

Sincerely,

MARY E. CLUTTER,
Assistant Director.

Enclosure.

NATIONAL SCIENCE FOUNDATION—REPORT FOR DEVELOPMENTS IN AGING

The National Science Foundation, an independent agency of the Executive Branch, was established in 1950 to promote scientific progress in the United States. The Foundation fulfills this responsibility primarily by supporting basic and applied scientific research in the mathematical, physical, environmental, biological, social, behavioral, and engineering sciences, and by encouraging and supporting improvements in science and engineering education. The Foundation does not support projects in clinical medicine, the arts and humanities, business areas or social work. The National Science Foundation does not conduct laboratory research or carry out education projects itself; rather, it provides support or assistance to grantees, typically associated with colleges and universities, who are the primary performers of the research.

The National Science Foundation is organized generally along disciplinary lines. None of its programs has a principal focus on aging-related research, although a substantial amount of research bearing various degrees of relationship to aging and the concerns of the elderly is supported across the broad spectrum of the Foundation's research programs. Virtually all of this work falls within the purview of the Directorate for Biological, Behavioral, and Social Sciences or the Directorate for Engineering.

DIRECTORATE FOR BIOLOGICAL, BEHAVIORAL, AND SOCIAL SCIENCES

The research projects supported by this directorate are designed to strengthen scientific understanding of biological and social phenomena. Research is supported across a spectrum ranging from the fundamental molecules of living organisms to the complex interaction of human beings and societal organizations. These projects are supported by six research divisions incorporating 26 research programs.

The Division of Behavioral and Neural Sciences supports research which is aimed at understanding the behavior of human beings and animals. To achieve this end, it uses molecular, developmental and cultural approaches while concentrating on model systems, behaving organisms, and cultures. Aging of the brain is known to involve the loss of neurons, changes in neural growth factors and neurotransmitter

systems and alterations in the shape of neurons and synapses. Currently supported research is addressing maintenance and regeneration of neurons, regulation of neurotransmitter systems, the plasticity of the nervous system, and hormonal mechanisms underlying adaptation to stress.

Anthropological research is being supported to study how economic and social change has affected traditional family behaviors associated with caring for dependent elderly in developing countries and to look at social, ethnic, and dietary factors affecting the incidence of high blood pressure in adults.

Research on human memory is examining long-term retention of material, including mathematics and Spanish, learned in college as a function of age.

Other research on the aging process in plants and animals is supported by the Division of Biotic Systems and Resources.

The Division of Social and Economic Science focuses primarily on expanding fundamental knowledge of how social and economic systems work. Attention is centered on organizations and institutions, and how they function and change, and how human interaction and decisionmaking take place. The Division supports the collection of large sets of data, such as national surveys, that are used by many investigators, as well as the research projects of individual scientists. Most of the work supported by this division has indirect, rather than direct, relevance to aging and the concerns of the elderly. For example, the Panel Study of Income Dynamics provides information on changing household composition, labor force participation, income, assets, and consumption patterns as individual respondents grow older. The General Social Survey contains several attitudinal questions relevant to older persons, such as the optimal age of retirement and government's role in the care of the elderly. This survey also permits the assessment—by age and by cohort—of shifts over time in opinions generally. The final survey supported by this division is the National Election Survey, which provides information on attitudes regarding candidates and issues held by different age groups in the population at large.

Current projects are addressing questions about the Social Security System, including how changes in the system may affect the labor supply of older workers, and status maintenance and change during old age.

DIRECTORATE FOR ENGINEERING

The National Science Foundation's Directorate for Engineering seeks to strengthen engineering research in the United States and, as appropriate, focuses some of that research on areas relevant to national goals. This is done by supporting projects across the entire range of engineering disciplines and by identifying and supporting special areas where results are expected to have timely and topical applications.

Most aging-related research supported by this directorate is through its Bioengineering and Aiding the Disabled Program, in the Division of Biological and Critical Systems. Most of this work is indirectly related to issues of aging and the elderly—its relevance derives from the increased propensity for the elderly to develop physical disabilities. Projects currently supported by this program include studies related to the musculoskeletal system. Among the projects falling into this category are several concerned with joint replacement including computer assisted design of the orthopedic surgeries, cementing techniques and failure detection of the devices. Other studies are being performed on orthoses and techniques to stabilize stance. Projects related to problems encountered with the cardiovascular system are currently supported and include work on tissue engineering for the replacement of arteries and veins. Still other research is directed at the sensory area with one such project related to signal processing techniques to compensate for hearing impairments. Finally, a number of studies are concerned with drug infusion and control techniques. While not specifically directed toward problems of aging, all of these studies have potential for dealing with conditions prevalent in the aging population.

ITEM 26. OFFICE OF CONSUMER AFFAIRS

DECEMBER 10, 1991.

DEAR SENATOR PRYOR: In response to your request, I have enclosed the "Report of Activities of the United States Office of Consumer Affairs During 1991 Relating to Older Americans."

My office is pleased to have the opportunity to contribute to the Committee's Annual Report on Aging. We are aware of the problems and concerns of our Nation's elderly consumers and will expand our activities in 1992 to provide even greater assistance.

If you have questions, please have your staff call Juanita Yates, OCA's Associate Director for Special Concerns, at 634-4297.

Sincerely,

ANN WINDHAM WALLACE,
Director.

Enclosure.

REPORT OF ACTIVITIES OF THE U.S. OFFICE OF CONSUMER AFFAIRS DURING 1991 RELATING TO OLDER AMERICANS

The Director of the U.S. Office of Consumer Affairs (USOCA) is Ann Windham Wallace, who directs consumer affairs activities at the Federal level. She also serves as Chairperson of the Consumer Affairs Council, established by Executive Order 12160. USOCA encourages and assists in the development and implementation of programs dealing with consumer issues and concerns; serves as the focal point for the coordination and standardization of Federal complaint handling efforts; works to improve and coordinate consumer education at the local, State and Federal levels; and cooperates with States and local government agencies, and voluntary consumer and community organizations in the delivery of consumer services and information materials.

The Office's major initiatives focus on voluntary mechanisms, marketplace innovations, consumer education and information, and conferences to exchange information and develop dialogues. USOCA efforts also focus on helping State and local government units and consumer and community groups to deal with issues affecting consumers.

Highlighted below are USOCA activities having the greatest impact on older Americans.

OUTREACH

MEETINGS AND CONFERENCES

The USOCA Director and staff frequently met with program staff from the American Association of Retired Persons and other aging constituency organizations to underscore the Administration's concern for the elderly and seek their support and views on policies which impact on the elderly.

USOCA provided consumer education materials and conducted workshops at a wide range of conferences and seminars sponsored by organizations representing elderly and disabled consumers. These included the National Caucus and Center on the Black Aged, National Council on the Aging, the American Association of Retired Persons, National Energy and Aging Consortium, Gallaudet University, and National Association of Adults with Special Learning Needs.

In March, USOCA cooperated with the National Consumers League in sponsoring a national conference on 900 Numbers. Participants included representatives of consumer organizations, government agencies, and the private sector. The conference participants made recommendations on how to decrease fraudulent uses of 900 number services without restricting their benefits to consumers, especially elderly consumers.

On April 9 in South Carolina and on November 14 in Washington, USOCA cooperated with the Direct Marketing Association in sponsoring Consumer Industry Dialogues. The purpose of the sessions was to discuss the problems of purchasing goods and services through the mail. Participants included representatives of the mail order industry, including the catalog, list selling, sweepstakes, telemarketing, and television marketing divisions. Postal inspectors, officials of Federal, state and local consumer protection offices and representatives of Better Business Bureaus also attended. The sessions addressed concerns of the elderly. Older individuals, who may be ill or have limited mobility, are particularly receptive to direct marketing solicitations and are most often the victims of fraud.

In recognition of Older Americans Month, USOCA's Associate Director for Special Concerns coordinated and presided at a special May 15 forum on "Serving Older Customers." The forum was cosponsored by USOCA, the American Association of Retired Persons and the Society of Consumer Affairs Professionals In Business.

As part of the national Blacks in Government Conference, the USOCA Associate Director for Special Concerns, conducted two workshops on "Elderly Care In An Aging America." The conference was held in August and attracted more than 2,000 Federal, State, and local government officials.

USOCA's Associate Director for Special Concerns participated in a Credit Education Conference which reviewed and evaluated publications and other materials tar-

geted for elderly and minority consumers. The conference also discussed strategies for the delivery of credit education materials to elderly and minority consumers. The conference was held in November and sponsored by the International Credit Association.

The National Energy and Aging Consortium (NEAC) will sponsor a conference on "Building Partnerships: Models for the Future" in January 1992. USOCA is a founding member of the NEAC which was established in 1981 to address the energy concerns of the elderly.

USOCA will participate in the SeniorNet Conference in June 1992. SeniorNet is a nonprofit organization which teaches computer skills to older adults.

USOCA is currently working on a health care communications project designed to improve communications between patients, hospitals and health insurance companies regarding billing, coverages and patient responsibilities. Project participants include Health Insurance Association of America, American Hospital Association and the National Society of Patient Representatives and USOCA. The intent of this effort is to improve the intelligibility of hospital bills and insurance coverage information and lower the incidence of large unexpected financial obligations on the part of patients. This would be especially helpful to older consumers who are frequent users of hospital services and are often on fixed, limited incomes.

MINORITY CONSUMER OUTREACH

In May and July, USOCA convened meetings with representatives of minority organizations on strategies for improving the delivery of consumer information to minority consumers. The meetings were in response to the Consumer Federation of America (CFA) 1990 Consumer Competency Survey that found disturbingly low levels of essential consumer knowledge among minority citizens.

As a result of the discussions, USOCA and CFR are planning three pilot Consumer Dialogues, the first will be held April 23-24, 1992, in San Francisco. With the assistance of local complaint handling agencies, the Dialogues will provide leaders of minority community-based organizations with information on how to get their constituency's consumer problems resolved. At the same time, the community leaders will discuss how the agencies can serve their communities more effectively.

Representatives of the American Association of Retired Persons participated in both meetings. Elderly consumers also scored low in the survey. Minority elderly will especially benefit from this new initiative.

INFORMATION AND EDUCATION

In October, USOCA released the sixth edition of its *Consumer's Resource Handbook*. It includes a section on aging and emphasizes other areas of assistance of special interest to the elderly, such as health care, Social Security, and veterans affairs. The State and local directory section lists government offices responsible for coordinating services for the elderly. The *Handbook*, available free from the Consumer Information Center (CIC) in Pueblo, CO, also provides consumer information on a number of issues of interest to older consumers, including health fraud, telephone solicitations, warranties, contracts, mail order and vacation certificates. In addition to the listing of Federal TDD numbers, the *Handbook* also includes TDD numbers of State and local government and corporate organizations. The *Handbook* was distributed to aging consumer organizations and State and area agencies on aging.

Also in October, USOCA released *Staying Healthy and Whole: A Consumer Guide to Product Safety Recalls*. Available free from the CIC, this leaflet lists the nine Federal agencies which issue consumer product safety warnings and recalls, the kinds of product each of them covers, and how to let them know about product safety problems or find out about warnings or recalls they have announced. In addition to the interest the elderly share with all consumers in avoiding unsafe foods, household products, appliances, et al., many older Americans are especially concerned with the safety of drugs, biologics, and medical devices, as well as manufactured housing (mobile homes), all of which are discussed in the leaflet.

USOCA distributed the *Special Report on Cold Stress and Heat Stress* which offers useful information on how to identify the causes and symptoms of these weather-related conditions that often threaten the lives of the elderly. Single copies of the *Report* are also distributed free from the CIC. USOCA has also provided bulk copies of the *Report* to aging organizations to be used at conferences, workshops, and seminars.

USOCA has also assumed responsibility for the distribution from the CIC of *Access Travel: Airports*. Published by the Airport Operators Council International, the guide lists important accessible design features, facilities, and services at 553

airport terminals worldwide for persons with disabilities and older persons. The guide is intended to encourage them to take full advantage of the increased level of accessibility to airports and the transportation opportunities available to them.

USOCA sends *Consumer News* to publications that target seniors each month. Many of the articles provided information about actions on behalf of or of particular interest to older consumers, usually not well covered in the general media. Included in the past year were:

The new Food and Drug Administration (FDA) requirement that manufacturers of breast implants give doctors information on the hazards. This information is to be passed along to patients.

The new law which provides that items designed to look like Federal checks or other Government correspondence will no longer be mailable, unless they carry a disclaimer saying they are *not* endorsed by the Federal Government.

An explanation of FDA's new labeling guidelines for pharmacists and physicians regarding the effects of prescription drugs in persons over 65 years of age. The guidelines take into consideration the changes in physiology associated with aging, including decreased kidney function, impaired liver, and decline in muscle tissue.

FDA approval of a new genetically engineered drug that can reduce the number of infections in cancer patients who may be at risk during chemotherapy. The drug will be marketed under the trade name Neupogen.

The new FDA rule requiring that the sodium content of oral over-the-counter drugs be included in all labeling when the product contains 5 mg. or more sodium per single dose.

A discussion of the new Federal proposals for labeling of meat, poultry, packaged foods, raw fruits and vegetables and seafood, as well as stricter standards for health claims on food labels, and an explanation of how to participate in the rulemaking process.

The USOCA Director was interviewed on a number of subjects affecting the elderly, including privacy and accuracy of credit records. She also wrote several articles of interest to elderly and disabled consumers including, "Hearing Impaired Consumers: An Untapped Resource for Business." Carried in the Direct Marketing Association's Catalog Newsletter, the article encouraged marketers to make their services accessible to the more than 20 million deaf and hearing impaired consumers, many of which are elderly.

On June 6, the Director testified on revisions to the Fair Credit Reporting Act before the House Banking Committee's Subcommittee on Consumer Affairs and Coinage. USOCA recommended changes to improve the accuracy and increase the privacy of credit records. The changes would also improve education to consumers by providing information at "teachable moments."

CONSUMER'S FORUM

In cooperation with the American Association of Community and Junior Colleges and the Prince George's Community College of Maryland, USOCA participated in the production of a two-part television series on privacy issues relating to telecommunications and credit. The series is designed to reach elderly consumers through home viewing and/or their participation in local community college programs. This form of outreach is particularly useful in providing information to the elderly because many are home bound. The series will be launched nationwide in January through the community college satellite network.

NATIONAL CONSUMERS WEEK

USOCA coordinated the 10th anniversary celebration of National Consumers Week (NCW) which took place October 20-26. The USOCA Director discussed the theme, "Today's Choice—Tomorrow's Opportunity," at a number of NCW activities throughout the country. Many of the activities addressed issues of interest to the elderly.

One major activity was the American Association of Retired Person's Consumer Action Award Reception. USOCA's Deputy Director Clayton Fong joined Horace Deets of AARP in honoring Florence Rice, 1991 Consumer Action Award recipient. Mrs. Rice, president of the Harlem Consumer Education Council, was recognized for her life-long contributions in educating low-income and minority consumers. In his remarks, Fong thanked her for the insight, counsel, and assistance she has given USOCA in expanding outreach and improving the delivery of information to minority consumers. President Bush recognized the dedication, commitment and tireless energy of Mrs. Rice during last year's National Consumers Week.

CONSTITUENT RESOURCE EXPOSITION

Since 1981, USOCA has organized a Constituent Resource Exposition (EXPO) for each new Congress to help eliminate Federal waste and duplication caused by misdirection of constituent complaints and inquiries. More than 1,000 Congressional staff assistants attended the sixth EXPO held April 1 at the Cannon House Office Building. Representatives of 37 Federal Agencies discussed agency programs and distributed publications. USOCA distributed more than 1,000 copies of our *1991 Congressional Liaison Handbook* that directs staffers to appropriate agency liaison officials and information materials. Following EXPO, the USOCA Director sent a copy of the *Handbook* to each Member of Congress. Because of the tremendous number of request from District Offices, USOCA reprinted the *Handbook* and distributed it to all Congressional District Offices. Many of the inquiries and letters of complaints that Congressional offices receive come from elderly citizens.

INTRAGOVERNMENTAL ACTIVITIES

INTERNATIONAL

In April and in October, the USOCA Director headed the U.S. Delegation to the Organization for Economic Cooperation and Development's (OECD) Committee on Consumer Policy Meetings in Paris. The Committee is composed of representatives from the 24 member countries. The Committee will conduct a study on issues relating to elderly consumers, including product safety and labeling. All issues addressed by the OECD are reviewed from a broad perspective and the concerns of the elderly are always reflected in final reports.

Throughout the year, the USOCA Director and staff met with government and consumer delegations from other countries. Issues of concern to elderly consumers were often addressed at these meetings.

COMMITTEES

USOCA was represented on the following committees which have a special impact on the elderly.

The National Energy and Aging Consortium is a network of 50 government, aging, and private sector organizations which have joined together to help the elderly cope with rising energy costs. The NEAC is working to establish State consortia.

The Information and Referral Consortium on Aging is a network of government, aging, and private sector organizations which provide information about and develop programs which strengthen information and referral systems throughout the country.

The Alliance Against Fraud in Telemarketing is a network of government agencies, consumer organizations, telecommunication companies, and marketing trade associations which provide consumer information on telemarketing fraud. The elderly are particularly vulnerable to telemarketing fraud. This is reflected in many of the written inquiries and complaints that USOCA receives each year from older Americans.

EXECUTIVE ORDER

The USOCA Director is designated by the President to be the Chairperson of the Consumer Affairs Council, established by Executive Order 12160. Executive Order 12160—the Consumer's Executive Order—is a directive to Federal agencies to institute consumer programs which are effective and responsive to the needs of consumers. This action is a logical progression from the Consumer Representation Plans of the 17 Executive Branch departments and agencies developed in 1976.

The Order addressed the problems of citizens in achieving adequate participation in Government decisionmaking processes. For example, agencies are required to develop information materials to inform consumers about their procedures for participation. Elderly consumers have been identified as a constituent group which should be reached with information. Under the Order, agencies must ensure that groups such as the elderly are being reached. Council member agencies report monthly to the Chairperson on their consumer-related activities. These reports provide information frequently incorporated in USOCA publications, presentations, and policy recommendations.

ITEM 27. PENSION BENEFIT GUARANTY CORPORATION

NOTE: The PBGC's report was not submitted prior to printing deadline.

ITEM 28. U.S. POSTAL SERVICE

DECEMBER 9, 1991.

DEAR MR. CHAIRMAN: This is in response to your October 2 letter to Postmaster General Anthony M. Frank, requesting information from the Postal Service on activities and programs which assist elderly Americans.

The enclosed document describes Postal Service programs which are designed to meet the mailing needs of older Americans and to prevent them from being victimized by mail fraud.

The Postal Service is pleased to contribute to this endeavor and will continue to develop programs to assist in improving the quality of life for the aging.

Sincerely,

WILLIAM T. JOHNSTONE.

Enclosure.

PROGRAMS AFFECTING OLDER AMERICANS

CARRIER ALERT PROGRAM

Carrier Alert is a voluntary community service provided by city and rural delivery letter carriers who watch participants' mailboxes for mail accumulations that might signal illness or injury. Accumulations of mail are reported by carriers to their supervisors, who then notify a sponsoring agency, through locally developed procedures, for follow-up action. The program completed its ninth year of operation in 1991 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 on hardship or special need. 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.

FEDERAL ACCESSIBILITY STANDARDS

The Postal Service is subject to the Architectural Barriers Act of 1968 which requires that most Federal buildings leased or constructed after 1968 meet applicable standards. The Postal Service is also affected by the *Rose* Decision which requires that any existing building with a lease action between January 1977 and April 1986 must be made accessible. Also, these provisions provide that any new quarters leased for the first time since April 1986 must be accessible prior to occupancy.

These accessibility standards apply to the majority of Postal Service facilities. Nearly 27,000 facilities have been surveyed, 6,000 projects have been completed, and approximately 10,000 projects are either in the design or construction stage. The Postal Service is committed to the Architectural Barriers Compliance Program which greatly benefits senior citizens as well as handicapped customers.

MAIL FRAUD AND MAIL THEFT INVESTIGATIONS

To many elderly Americans living alone and on fixed incomes, shopping by mail is a convenient way for them to obtain products and services. Unfortunately, they are also attractive targets for a few individuals who operate mail-order swindles. Through mail fraud and misrepresentation of products and services, unscrupulous promoters not only cheat the public but also damage the reputation of the legitimate mail-order industry.

There are several types of fraudulent promotions which, by their nature, tend to focus on the elderly population. One of the most widespread is the work-at-home scheme. Senior citizens seeking to supplement their incomes may be enticed by advertisements promising enormous earnings while working from the convenience of home. The scheme begins with the promoter requiring an initial fee, typically from \$5 to \$25, before information about the plan is supplied. The fraud continues as a pyramid operation, whereby the consumer involves others in the scheme, resulting in funds being generated to the promoter and not the respondents.

Individuals approaching retirement or those already retired sometimes respond to what appear to be attractive land sales deals. The promise of a warmer climate, low

down payment, and easy monthly installments appears enticing until the purchaser discovers that the parcel of land is located in a desert wasteland and cannot be resold for even a fraction of the price paid.

Another fraud perpetrated against elderly customers is the mail-order sale of worthless pills, nostrums, and devices which promise to rid the aged of needless suffering. Probably the cruelest of these frauds are those that offer hope for cure of cancer, diabetes, and other major illnesses.

The ailments and afflictions that are a part of aging will leave the buyer looking for a magical cure to alleviate arthritic pain, restore lost vigor, and improve impaired sight or hearing. These pills and devices often have not been tested by medical authorities, are not capable of curing, and could even be injurious to one's health.

In an effort to heighten public awareness of mail fraud and other postal-related crimes, the Postal Inspection Service maintains across the country a cadre of Postal Inspectors trained as Crime Prevention Specialists. Working with Federal and State agencies and consumer groups, one of their missions is to educate and inform the public. Each year they appear on hundreds of television and radio interview programs and prepare articles for numerous newspapers and magazines. They give presentations at health fairs, community action groups, and national prevention conferences emphasizing the need for consumer awareness in fighting crime. They respond to special requests, often from senior citizens, regarding specific problem areas.

Over the past 8 years, the Postal Inspection Service has issued a series of public service announcements alerting the public to fraud schemes operating through the mails. In 1989, the Inspection Service contracted for the production of a Video News Release on fraudulent "Boiler Room" operations which often target the elderly. The release was distributed via satellite to over 600 stations across the country, and in many instances, was customized to parallel local consumer problems.

In 1991, the Postal Inspection Service produced a Video News Release (VNR) on the use of 900 numbers in fraudulent promotion schemes. While the VNR was designed for a general audience, it is particularly useful to elderly customers, who are often victims of 900 fraud.

In a recent 900 number scheme that resulted in a Federal Grand Jury indictment, customers were notified by "Phone/Mail-A-Grams" that they had won a prize. Everyone heard the same pre-recorded message with the instruction to call a 900 number to learn which of three prizes would be received. Ironically, each caller received the same prize—the "\$1,000 discount shopping spree!" The promoters issued a four-page catalog, containing 14 items, and a coupon booklet that could only be used for catalog merchandise. Additionally, cash payments were required on all purchases. Unsuspecting customers made in excess of 30,000 calls to the 900 number at a consumer cost of approximately \$278,125.

Since 1986, the Postal Inspection Service has participated in the National Health Care Anti-Fraud Association Seminars and has worked with this association to combat health care frauds, many of which victimize senior citizens. The Postal Inspection Service has participated in conventions sponsored by the National Council on Aging. At display booths, the Postal Inspection Service representatives highlight various types of fraud schemes which target the elderly.

Despite the existence of such preventive efforts, the number and variety of mail fraud schemes ensure that many people will continue to be victimized by mail fraud promotions. In dealing with this, the Postal Service uses a two-pronged attack. Criminal prosecution is possible under the Mail Fraud Statute, 18 U.S.C. Section 1341, which provides penalties of up to 5 years in prison and a \$1,000 fine for those who use or cause the mail to be used to further a fraudulent scheme. Second, and perhaps more important for the consumer, the Postal Service can take action under the False Representations Statute, 39 U.S.C. Section 3005. This statute permits the Postal Service, following a full due process hearing before an administrative law judge, to return to the sender all mail addressed to a promotion whose advertisements soliciting remittances by mail are proven to contain false representations. In addition, the Postal Service may request the U.S. District Court, in the area where the promotion receives its mail, to issue a temporary restraining order to stop the delivery of mail to that promotion until the administrative law judge renders a decision.

A crime which strikes the elderly population particularly hard is mail theft. Many poor and elderly Americans depend on the receipt of a monthly check in the mail as their sole income. These individuals suffer greatly when their checks do not arrive as scheduled. Each year the Postal Service delivers hundreds of millions of Federal, State, and local benefit checks. Although the number of stolen checks in

relation to the number mailed is minute, the Postal Inspection Service considers this a significant problem and recognizes the impact this crime has on the victim, particularly on elderly persons who are dependent upon the checks for subsistence. The Postal Service also delivers millions of personal and commercial checks and other valuable items such as savings bonds, money orders, credit cards, and food stamps, all of which are appealing targets for mail thieves.

Two slide presentations, entitled "Protecting Your Mail" and "Fraud By Mail" have been developed and are being shown to the public by Crime Prevention Specialists. A Postal Service booklet, "A Consumer's Guide to Postal Crime Prevention," has been updated to include new information. It furnishes tips to consumers on how to avoid being victimized by fraudulent schemes and mail theft. This booklet also includes the addresses of Postal Inspection Service Divisions throughout the country.

A series of investigative programs to combat the problem of mail theft is also in place. Postal Inspectors cooperate with the U.S. Secret Service and local police investigating the forgery of checks believed to have been stolen from the mail. They also work with officials of check issuing agencies to improve procedures for the prompt charge-back of checks and referral of information whenever theft from the mail is suspected. The Postal Service has encouraged the development of better photo and signature identification cards and has enlisted the cooperation of public housing authorities to install and maintain more secure mail receptacles and mail rooms.

INJUNCTIONS AND OTHER CIVIL POWERS

In addition to the investigation of individuals or corporations for possible criminal violations, the Postal Inspection Service can protect consumers from material misrepresentations through the use of several statutes. In less severe cases, operators of questionable promotions agree to a Voluntary Discontinuance. This is an informal promise to discontinue the operation of the promotion. Should the agreement be violated, formal action against the promoter could be initiated. In certain cases where a more formal action is better suited, a Consent Agreement is obtained. Generally, a promoter signs a Consent Agreement to discontinue the false representations or lottery charged in a complaint. If this agreement is violated, the Postal Service may withhold the promoter's mail pending additional administrative proceedings.

The Postal Service (Judicial Officer) is empowered under 39 U.S.C. 3005(b)(2) to issue a Cease and Desist (C&D) Order which requires any person conducting a scheme in violation of Section 3005 to immediately discontinue. C&D Orders are issued as part of a False Representation Order and, as a matter of course, are agreed to as part of a Consent Agreement. Violations of C&D Orders may be subject to civil penalties under 39 U.S.C. 3012. When more immediate relief to protect the consumer is warranted, the Postal Service has a number of effective enforcement options available. Title 39 U.S.C. 3003 and 3004 enables the Postal Service, upon determining that an individual is using a factitious, false, or assumed name, title, or address in conducting or assisting activity in violation of 18 U.S.C. Sections 1302 (Lottery), 1341 or 1342 (Mail Fraud), to withhold mail until proper identification is provided and the person's right to receive mail is established.

In those instances where a more permanent action is necessary, 39 U.S.C. 3007 allows the Postal Service to seek a Temporary Restraining Order detaining mail. By withholding service to the suspected violator, the extent of victimization is limited while an impartial judge reviews the facts and makes a final determination. If the judge decides that all mail pertaining to the promotion should be returned, then a False Representation Order, authorized under 39 U.S.C. 3005, is issued. In addition, U.S. District Judges may hold a hearing on alleged fraudulent activity, and issue a permanent injunction regarding the operation pursuant to 18 U.S.C. 1345.

By requesting the court to withhold mail while a case is argued, Postal Inspectors have been successful in many cases in limiting the extent of victimization. Action under these statutes does not preclude criminal charges against the same target.

NATIONAL CONSUMERS' WEEK/CONSUMERS' PROTECTION WEEK

The Postal Service has sponsored an annual Consumer Protection Week since 1977. Since 1980 the Postal Service's Consumers' Protection Week has been scheduled to coincide with National Consumers' Week. Promotion and publicity kits are prepared and distributed to warn consumers about mail fraud and misrepresentation of products and services sold by mail. Additional information about proper addressing of mail, address changes, and how to report service problems are also beneficial to senior citizens and are included in the kit. As medical fraud and work-at-

home schemes have traditionally ranked at the top of fraudulent promotions, the focus of material distributed has frequently been directed toward alerting senior citizens of such schemes.

STAMPS BY MAIL

Stamps by Mail (SBM), one of the Easy Stamp Services, allows customers to purchase postal products by ordering through the mail. These products include stamps in booklet, sheet, and coil form, postal cards, stamped envelopes, and philatelic items. The SBM program benefits a wide variety of people and is particularly beneficial to elderly or shut-in customers who cannot travel to the post office. The SBM order form, which incorporates a self-addressed postage-paid envelope, is available in lobbies or from city delivery carriers. The customer fills out the order form and returns it to the carrier or drops it in a collection box. Orders are normally returned to the customer within 5 business days. SBM is used primarily by city delivery customers; rural and highway contract route customers obtain similar products from their carriers using Form 3227-R.

STAMPS BY PHONE

Stamps by Phone is a convenience program that is intended to target the 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. The customer calls the (1-800-STAMPS-24) toll-free number, 24 hours a day, 7 days a week, and orders from a menu of postal products. There is no minimum amount and customers will receive their order within 3 to 5 business days.

WINDOW AUTOMATION AT RETAIL FACILITIES

Automated systems, called Integrated Retail Terminals, have been installed at retail facilities in most medium to large cities. These terminals use video screens to display information about each transaction for the customer. The screens show some mailing restrictions and required mailing forms, total amount due, and change from the amount tendered. The display of this type of information is useful to many customers with hearing impairments, including some older Americans.

Some post offices have installed call lights that are used to summon customers to the next available retail counter with both a slowly flashing light and a pleasant chime. This is helpful for customers with either impaired hearing or sight. In addition, some retail units with space available in their service lobbies have installed benches or chairs for senior citizens and handicapped customers.

LOBBY DIRECTOR PROGRAM

Some post offices have implemented the lobby director program. Lobby directors assist customers in preparing forms, explain postal products and services, and offer general information as the customer enters the lobby. This program improves customers' ability to receive the best value for their purchase of postal services or products. This is especially important to those on fixed incomes.

ALTERNATE POSTAL RETAIL SITES

Alternate postal retail sites include retail, or contract postal units, and stamp consignment outlets (grocery stores, etc). Providing alternative sites for routine postal retail transactions benefits both the Postal Service and our customers.

More convenient locations available for customers to purchase stamps, generally means less time for them to obtain these retail services. Purchasing stamps and postal money orders, registering a letter, and other postal errands, can be combined with a trip to the neighborhood shopping center. This is particularly advantageous to the elderly.

ITEM 29. RAILROAD RETIREMENT BOARD

DECEMBER 16, 1991.

DEAR MR. CHAIRMAN: In response to your letter of October 2, 1991, we are enclosing a report summarizing the U.S. Railroad Retirement Board's program activities for the elderly during fiscal year 1991.

We look forward to your committee's report, *Developments in Aging: 1991*. If we can be of further assistance, please feel free to contact the Board Chairman's office at (312) 751-4900.

Sincerely,

GLEN L. BOWER.
ANDREW F. REARDON.

Enclosure.

U.S. RAILROAD RETIREMENT BOARD ANNUAL REPORT ON PROGRAM ACTIVITIES FOR THE ELDERLY FOR FISCAL YEAR 1991

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. Annuities based on age are payable at age 62, or at age 60 for employees with 30 years' service. Disability annuities are payable before retirement age on the basis of total or occupational disability. Annuities are also payable by the Board 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.

The Board is headed by three members appointed by the President of the United States. The Chairman is Glen L. Bower, the Labor Member is Charles J. Chamberlain, and the Management Member is Andre F. Reardon. The President also appoints the Inspector General, William J. Doyle III.

BENEFITS AND BENEFICIARIES

During fiscal year 1991, benefits paid under the railroad retirement and railroad unemployment insurance programs totaled almost \$7.6 billion. Retirement and survivor benefits amounted to \$7.5 billion, and unemployment and sickness benefits totaled \$80 million. The number of beneficiaries on the retirement-survivor rolls on September 30, 1991, totaled 873,000. The majority (84 percent) were age 65 or older.

At the end of the fiscal year, 389,000 retired employees were being paid regular annuities averaging \$958 a month. Of these retirees, 191,000 were also being paid supplemental Railroad Retirement annuities averaging \$45 a month. In addition, approximately 216,000 spouses and divorced spouses of retired employees were receiving monthly spouse benefits averaging \$393 and, of the 279,000 survivors on the rolls, 241,000 were aged widow(er)s receiving monthly survivor benefits averaging \$578. Approximately 11,000 retired employees were also receiving spouse or survivor benefits based on their spouses' railroad service.

The annuities of 215,000 of the 873,000 beneficiaries included vested dual benefits. These benefits preserve equities of annuitants insured for both Railroad Retirement and Social Security benefits prior to the Railroad Retirement Act of 1974, which provided for a phaseout of dual benefits.

Railroad Retirement annuities, like Social Security benefits, are being increased in January 1992 to reflect a 3.7-percent increase in the Consumer Price Index (CPI) during the 12 months preceding October 1991. Cost-of-living increases are calculated in each of the two tier portions of Railroad Retirement annuity. Tier I portions, like Social Security benefits, increase in January 1992 by 3.7 percent, which is the percentage of the CPI rise. Tier II portions increase by 1.2 percent, which is 32.5 percent of the CPI rise. In 1992, the average regular Railroad Retirement employee annuity rises over \$27 to \$986 a month and the average spouse benefit increases about \$10 to \$403 per month. For aged widow(er)s, the average monthly benefit rises over \$18 to \$597. Vested dual benefit payments and supplemental annuities also paid by the Board are not adjusted for the CPI rise.

Some 776,000 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 1991. Of these, 760,000 (98 percent) were also enrolled for supplemental medical insurance.

Unemployment and sickness benefits under the Railroad Unemployment Insurance Act were paid to 52,000 railroad employees during the fiscal year. However, only about \$0.3 million (less than 1 percent) of the benefits went to individuals age 65 or older.

BENEFIT FINANCING

By the end of the 1991 fiscal year, the equity balance in the Railroad Retirement Account had increased from \$9.1 billion to \$9.6 billion and the Railroad Unemployment Insurance Account's debt to the Railroad Retirement Account had been reduced to \$271.6 million.

Just before the beginning of the 1991 fiscal year, the Commission on Railroad Retirement Reform, which had conducted a comprehensive study of long-term Railroad Retirement financing issues, released its report to Congress. Assuming that the Railroad Retirement System continues without significant structural changes, the Commission unanimously concluded that the system is financially sound in the intermediate term and will not experience cash-flow difficulties during the next 20 to 25 years. While the long-term financial viability of the system is less certain, the Commission concluded that it is quite probable it is financially sound over the next 75 years.

In June 1991, the Board Transmitted to Congress its 18th actuarial valuation of the Railroad Retirement program's assets and liabilities, which projected income and outgo under four employment assumptions. The valuation concluded that, barring a sudden, unanticipated, large drop in railroad employment, the Railroad Retirement System will experience no cash-flow problems for at least 20 years. The long-term stability of the system however, remains questionable, and under the current financing structure, actual levels of rail employment in the coming years will determine whether additional corrective action is necessary.

The Board's 1991 report to the Congress on the financial status of the railroad unemployment insurance system was also favorable. This report estimated that maximum benefit rates will increase 42 percent (from \$31 to \$44) from 1990 to 2000, but experience-based contribution rates will keep the system solvent, even under the most pessimistic assumptions, that average employer contribution rates drop significantly from 1991 to 1993, that existing loans, from the Railroad Retirement Account will be fully repaid by the end of calendar year 1994, and that no new loans will be required during the projection period.

MANAGEMENT IMPROVEMENT PLAN

The Railroad Retirement Board was among the first group of Federal agencies to undergo intensive reviews of their administrative management operations, under a governmentwide program conducted by the White House Office of Management and Budget. Following a 2-week on-site review by an OMB review team and months of analysis and planning, Railroad Retirement Board and OMB officials agreed on a \$14 million, 5-year plan for administrative improvements in the areas of claims adjustment backlogs, debt collection, fraud control, tax accounting, trust fund integrity, and information systems. The 1992 Federal budget includes approximately \$3 million to fund the first year of this agreement. These funds were provided in addition to the Board's administrative budget for the 1992 fiscal year.

The agreement requires that cost-effectiveness be the primary criterion for the expenditure of these funds, so that the investment will yield significant results in reducing material weaknesses in the agency's internal controls and effect savings in future administrative costs.

The commitment of these additional resources is considered essential to effecting long-term improvements. With this commitment of funds, the Board plans to eliminate claims adjustment backlogs without compromising accuracy, enhance debt collection activities with new initiatives, ensure the accuracy of statements issued to beneficiaries for income tax purposes, expand electronic fraud control activities to all areas of the country while increasing fraud deterrence activities, and increase monitoring of Railroad Retirement payroll tax collections. Enhanced information systems will provide the Board with increased capability to carry out these plans. The RRB-OMB agreement requires monitoring of the application of the additional resources being provided to the Board, and measurement of the progress made toward the goals of the plans.

PUBLIC INFORMATION ACTIVITIES

The Board maintains direct contact with Railroad Retirement beneficiaries through its 90 field offices located across the country. Field personnel explain benefit rights and responsibilities on an individual basis, assist 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 held 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 describing in detail the benefit provisions as well as the administration and financing of the programs.

At seminars for railroad executives and managers, Board representatives review the benefit programs, financing, and administration, with special emphasis on those areas which require cooperation between railroads and Board offices. These meetings have facilitated cooperation and coordination, and they help keep railroad officials up-to-date on the Board's benefit programs.

IMPROVED APPLICATION PROCESS

To ease the process for filing applications, the Board revised its procedures so that railroad employees may now file annuity applications by telephone and mail without having to visit a field office or an itinerant point. Applicants filing by telephone receive the same information and instructions that are provided to those filing in person. Forms requiring signatures and other documents are then handled by mail. Spouses and survivors may also file applications for benefits by telephone.

This "file by phone" procedure is one of a series of changes the Board has made to improve processing of Railroad Retirement benefit payments to new retirees and making filing applications more convenient. Applicants also can now file applications up to 3 months in advance of their planned retirement date, which allows the Board to complete the processing of most new claims by a person's retirement date and initiate payments about 30 days later. The "file by phone" procedure makes it more convenient for retiring employees to file their applications before their actual retirement. In order to enhance the application process for the Hispanic community, the Board has published a retirement-survivor benefit information booklet in Spanish; it previously published a Spanish-language booklet on unemployment benefits.

OFFICE OF INSPECTOR GENERAL

The Railroad Retirement Board's Office of Inspector General continued to provide comprehensive audit and investigative coverage of Board programs in fiscal year 1991. Office of Inspector General efforts have resulted in major contributions towards the improvement of the economy and effectiveness of Board operations, and the creation of a deterrent against fraud, waste, and abuse. The Inspector General operations include an Office of Audit and an Office of Investigations.

In fiscal year 1991, the Inspector General's Office of Audit issued 29 reports with actual and potential monetary benefits totaling \$64.3 million. In addition, the Railroad Retirement trust funds received approximately \$10 million in interest as a result of a prior audit.

Following audits of compensation reporting and tax compliance by railroad employers, the OIG, since August 1988, has issued 45 railroad employer audit reports, identifying over \$30 million in potential taxes that may be due but uncollected under the Railroad Retirement Act. New audits of railroad employers have been suspended because of litigation concerning the OIG's authority to conduct such audits. The OIG is working closely with the Board and the Department of Justice to resolve the issues raised by the litigation and the Board and the OIG are discussing courses of action to ensure full compliance by the Nation's railroad employers.

The Office of Audit also performed internal reviews on strengthening the selection process of representative payees; data processing internal control systems; procedures used for the transfer of tax information among the Internal Revenue Service, Department of Treasury, Social Security Administration, and the Board; actions taken by Board management to eliminate two major backlogs; the timeliness of appeals processing; and the Board's internal control procedures and reporting process.

During fiscal year 1991, the Inspector General's Office of investigations obtained 115 criminal convictions, 57 indictments/informations and \$2.8 million in recoveries, restitutions, fines, and prevention of financial loss.

Significant investigations addressed fraud violations of the Medicare and disability benefit programs, retirement fraud involving the theft and fraudulent cashing of U.S. Treasury checks and fraud involving railroad employees claiming and receiving unemployment or sickness benefits while working and receiving wages from an employer.

SERVICE TO THE PUBLIC

The Member of the Railroad Retirement Board, its staff, the Office of Inspector General, and the Office of Management and Budget are all committed to maximizing economy and efficiency in Board operations and providing beneficiaries with the best possible service. In a message transmitting the Board's 1991 Annual Report to the Congress, President Bush stated:

Both OMB and RRB are committed to many substantial reforms, and the RRB leadership is demonstrating a new and progressive approach to addressing inefficiencies, debt collection, and automation modernization. I commend the Board for its efforts and urge the Congress to support appropriations for these measures to enhance RRB efficiency, eliminate material weaknesses, and to protect the integrity of the trust funds. The RRB Inspector General's Office also deserves praise for its diligence in monitoring and enforcing industry compliance with the pension contribution statutes. Such efforts help to preserve the integrity of the rail pension funds, on which rail employees and retirees depend.

ITEM 30. U.S. SMALL BUSINESS ADMINISTRATION

DECEMBER 26, 1991.

DEAR SENATOR PRYOR: Thank you for your letter of October 2, 1991, concerning The Senate Special Committee on Aging and the preparation of its annual report, "Developments in Aging." Our reply this year reflects no substantial change from last year.

The Small Business Administration (SBA) does not directly address the needs of older Americans. The varied services and programs sponsored by SBA are available to all citizens and we encourage older Americans to take advantage of them.

We do sponsor a particular program which may offer unusually attractive services to the older citizens. This program, the Service Corps of Retired Executives (SCORE), has recently celebrated its 25th year of volunteer service. The SCORE program, sponsored and funded through SBA, provides free counseling and low-cost training to Americans who wish to go into business or who already own small businesses.

I have taken the liberty of enclosing some information about SCORE that you may find helpful. Please let me know if there is anything further you wish to know.

Because the vast bulk of the 13,000 volunteer members of SCORE are retired, they share a bond of age with older Americans. The program offers two distinct services to these citizens. First, SCORE offers a broad program of advice and training to those who may be interested in a new career. And second, SCORE offers a rewarding outlet for energies and experience to those who may wish to give something back to their country.

Again, thank you for your letter. I hope that I have been of some help and I appreciate your interest in small businesses.

Sincerely,

PATRICIA SAIKI,
Administrator.

*Facts For Small
Business From*

SCORE®

*The Service Corps of Retired
Executives Association*

Providing:

- *Confidential Counseling*
- *Training and Workshops*
- *Business Information*
- *Business Management Help*

CALL: 1-202-205-6762
or your nearest SCORE Chapter

A. QUESTIONS TO ASK YOURSELF BEFORE GOING INTO BUSINESS:

1. Is my product or service different from others already in my market area?
2. Do I have the right kind of business experience?
3. Can I prepare a credible, detailed business plan for the first three years?
4. Am I able to take responsibility?
5. Am I a good organizer?
6. Am I ready to put in the long hours that might be necessary?
7. Am I ready to stick to it even during the rough times?
8. Do I have the support of my immediate family?
9. Do I have adequate resources and credit—and maybe a little bit more?
10. Is my health up to the tasks ahead?

B. QUESTIONS TO ASK YOURSELF IF ALREADY IN BUSINESS

1. Is my sales volume higher than a year ago?
2. Am I making money from my business?
3. Is my inventory the right size and balance?
4. In terms of business, is my family protected if I should die?
5. Where will technology take my business in 5-10 years?
6. Are my customers satisfied?

7. Is my location improving or deteriorating?
8. Are my accounts payable due before my receivables arrive?
9. Do I have a business plan?
10. Should I expand?

C. STEPS IN PREPARING AND SECURING A LOAN

1. A detailed description of the business you plan to start: include product or service, market, start-up costs, equipment, working capital, inventory (see also section H).
2. Explain your experience and capabilities and those of your associates.
3. Prepare a financial estimate of your own resources, those of associates and how much you need to borrow.
4. Try to project cash flow for the first three years of business. Show how you will use the business to payback your loan.
5. What collateral can you, your associates, and your family come up with to secure your loan?
6. Review your loan package with a SCORE counselor.
7. Review your loan package with your loan officer. Show your proposal and projections, ask for a direct loan. If turned down, ask to have the bank make the loan under SBA Guaranteed Loan Program.

D. SMALL BUSINESS INDUSTRIES CREATING THE MOST NEW JOBS*

1. Eating and Drinking Places
2. Offices of Physicians
3. Computer and Data Processing Services
4. Nursing and Personal Care Facilities
5. Trucking and Trucking Terminals
6. Miscellaneous Business Services
7. Outpatient Care Facilities
8. Machinery, Equipment and Supplies
9. Residential Care
10. Mailing, Reproduction and Stereo Services

E. FASTEST GROWING SMALL BUSINESS INDUSTRIES*

1. Outpatient Care Facilities
2. Medical and Dental Laboratories
3. Mailing, Reproduction and Stereo Services
4. Automotive Rental (without drivers)
5. Electrical Repair Shops
6. Computer and Data Processing Services
7. Railroad Equipment
8. Residential Care
9. Offices of Physicians
10. Sporting Goods, Toys, Hobby Goods

* The lists for D and E are taken from the most recent data available, however, the compilation of such specific data is time-consuming. This data is for the period Dec. 1988-Dec. 1989. While this data may have implications for the present, a person considering starting or buying a similar business should consider the local economy, competition, location and other factors contributing to the success of a business venture. A free consultation with an experienced SCORE counselor can provide important information in this regard.

G. PRINCIPAL TOPICS OF SCORE WORK SHOPS

1. Pre-Business Planning
2. Accounting and Finance
3. Marketing
4. Sales
5. Women's Business Ownership
6. Veteran's Business Ownership
7. International Trade
8. Expansion
9. Taxes and Tax Accounting
10. Franchising

H. 10 STEPS TO HELP YOU PREPARE A BUSINESS PLAN

1. RESEARCH: Get as much info on your proposed business as possible—from talking to those already in business, from the library,

trade associations or trade publications, local and federal agencies.

2. PROJECTIONS: The more you know about your business, the more accurately you can make projections of sales and potential profits for the first year—but preferably for the first three years.
3. CAPITAL: Accept the fact that it always takes more money than you anticipated, have enough working capital on hand and backup resources in case the new business does not prosper as you had anticipated.
4. COMPETITION: Study them carefully; they have been there and experienced what you are about to discover.
5. LOCATION: Remember the real estate adage: location, location, location. If you can't go to your customer, your customer must come to you. So it's either prime location or lot's of advertising.
6. IMAGE: What kind of public image do you want to create with your service, merchandise, quality, decor, packaging, personnel, vehicles, ads, pricing?
7. RECORDS: Complete, accurate records are needed for tax purposes, your bank account and most important, for your own guidance. You might fool others for a while, but you should not fool yourself.
8. PROFESSIONAL HELP: In addition to SCORE counseling, rely on a competent lawyer, accountant and banker. It's also important to have a good insurance broker and marketing professional.
9. BUYING: Knowing what, when and where to buy and how to gauge inventory can make or break you. It allows you to conserve working capital, reduce obsolescence, meet and beat the competition.
10. PROFIT: This is the bottom line for which you are going into business. Make sure that all expenses are accounted for, including your own living costs, possible losses, shrinkage, unseen costs such as fringe benefits and taxes. Then add a legitimate profit to your risk. If the profit does not come out right, perhaps you should rethink the idea of...

GOING INTO BUSINESS:

DON'T UNDERESTIMATE THE VALUE OF A BUSINESS PLAN. A well researched business plan can make or break your loan application—even your business! A review of your plan with a SCORE counselor before you visit your banker can mean the difference between acceptance and rejection. And it will cost you nothing.

I. SCORE HAS:

1. Free, confidential counseling from 13,000 experienced business professionals from a myriad of backgrounds.
2. 380 chapter locations around the country.
3. An additional 380 branch locations for added convenience of suburban or rural dwellers.
4. Counseled over 2.5 million clients since 1964.
5. Workshops covering basic and advanced business topics.

SCORE, the Service Corps of Retired Executives Association, is funded by the U.S. Small Business Administration. For further information, please write:

The National SCORE Office
409 Third St. SW Suite 5900
Washington, DC 20024
Or call: 202-205-6762

ITEM 31. DEPARTMENT OF VETERANS AFFAIRS

JANUARY 22, 1992.

DEAR MR. CHAIRMAN: I am pleased to respond to your request for a report of the Department of Veterans Affairs activities on behalf of older persons for the calendar year 1991.

VA has developed a high quality system that provides health care for thousands of elderly veterans every day. Meeting the medical needs of older veterans constitutes one of VA's current greatest challenges.

Thank you for allowing us the opportunity to share this information with you.

Sincerely,

EDWARD J. DERWINSKI.

Enclosure.

ANNUAL REPORT TO SENATE COMMITTEE ON AGING, DEPARTMENT OF
VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION

I. INTRODUCTION

The Department of Veterans Affairs (VA) has the potential responsibility for a beneficiary population of nearly 27 million veterans whose median age is 55.3 years. Approximately 27 percent of the veteran population is age 65 and older and will increase to 37 percent by the year 2000. While the total number of veterans will decline, those over the age of 65 will rise to almost 9 million and by the year 2005 almost 4½ million will be 75 years or older.

This demographic trend will require the VA to redistribute its resources to meet the different needs of this older population. Historically, older persons are greater uses of health care services. The number of physician visits, short-term hospital stays, and number of days in the hospital 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, noninstitutional, and community settings to ensure that the physical, psychiatric, and socioeconomic needs of the patient are met. Special projects, a variety of innovative, medically proven programs and individual VA medical center 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 172 hospitals, 126 nursing home units, 35 domiciliaries, and 226 outpatient clinics. Veterans are also provided contract care in non-VA hospitals and in community nursing homes, fee-for-service visits by non-VA physicians and dentists for outpatient treatment, and support for care in 63 State Veterans Homes in 38 States. As part of a broader VA and non-VA network, affiliation agreements exist between virtually all health care facilities and nearly 1,000 medical, dental, and associated health centers. This affiliation program with academic medical centers results in about 100,000 health profession students receiving education and training in VAMC's each year.

In addition to VA hospital, nursing home and domiciliary care programs, VA is increasing the number and diversity of noninstitutional extended care programs. The dual purpose is to facilitate independent living and keep the patient in a community setting by making available the appropriate supportive medical and human services. These programs include Hospital-Based Home Care, Community Residential Care, Adult Day Health Care, Respite Care, and Psychiatric Day Treatment and Mental Hygiene Clinics.

The need for both acute and chronic hospitalization will continue to rise as older patients experience a different mix of diseases than younger patients. Cardiovascular diseases, chronic lung diseases, cancers, organic brain 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. More often the older individual has more than one chronic condition, and the conditions tend to be progressive, degenerative, and permanent, requiring long-term rehabilitation and care.

In 1975 the Veterans Health Administration (VHA) initiated the Geriatric Research, Education and Clinical Center (GRECC) program. The GRECCs were designed as centers of excellence for the advancement and integration of research, education, and clinical achievements in geriatrics and gerontology in VA. At the present time, there are 15 GRECCs throughout the VA system.

Finally, to meet the challenge of the growing aging population, VA through its long-range planning system is identifying underutilized hospital beds that can be converted to nursing home and domiciliary care beds for the future demand.

II. GERIATRICS AND EXTENDED CARE PROGRAMS

VA NURSING HOME CARE

The Nursing Home Care Units, which are based at VA medical centers, provide skilled nursing care and related medical services. An interdisciplinary approach to care is employed which encourages diverse professional staff, working together, to meet the multiple physical, social, psychological, and spiritual needs of the patients. Nursing home patients typically require a prolonged period of care and/or rehabilitation services to attain and/or maintain optimal functioning.

In fiscal year 1991, more than 28,000 veterans were treated in 126 VA nursing homes which had an average daily census greater than 12,000. This year saw a net increase of 1,320 beds in the nursing home program through either new construction or conversion of acute and intermediate care beds for a total of 14,532 nursing home beds.

There are several initiatives that have gathered momentum this year. A National Training Program has just completed a second year preparing staff to better meet the needs of the mentally ill in the nursing homes. At the same time, individual facilities are working to reduce both the incidence of polypharmacy and of restraint use in keeping with the regulations of the Omnibus Reconciliation Act of 1987 even though VA is not required to follow these regulations. Finally, several test sites have begun implementation of a common data base (in this instance, a document known as the Minimum Data Set) which, eventually, will be introduced throughout the nursing home.

COMMUNITY NURSING HOME CARE

This is a community-based, contract program for veterans who require skilled or intermediate nursing care when making a transition from a hospital to the community. Veterans who have been hospitalized in a VA facility for treatment, primarily of a service-connected condition, may be placed at VA expense for as long as they need nursing care. Other veterans may be eligible for placement in community facilities at VA expense for a period not to exceed 6 months. Selection of nursing homes for a VA contract requires the prior assessment of participating facilities. Follow-up visits are made to veterans by teams from VA medical centers to monitor patient programs and quality of care.

In fiscal year 1991, 28,831 veterans were treated in the program. The number of nursing homes under contract was 3,139 in fiscal year 1991. The average daily census in these homes for fiscal year 1991 was 8,347.

VA DOMICILIARY CARE

Domiciliary care in VA facilities provides necessary medical and other professional care for eligible ambulatory 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. The domiciliary with increasing frequency, 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 increasing numbers 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 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 in the community as part of the 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 1991, more than 19,000 veterans were treated in VA domiciliaries with an average daily census of 6,603. (Of these numbers, approximately 3,500 veter-

ans and an average daily census of more than 1,000 were admitted to the domiciliary care for homelessness. This group has an average age of 43 years, while the overall average age is 59 years.)

STATE HOMES

The State Home Program has grown from 11 homes in 11 States in 1888 to 67 State homes in 40 States. Currently, a total of 20,148 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 care, nursing home care, or hospital care in State home facilities. The other VA grant program provides up to 65 percent Federal funding in the cost of construction or acquisition of new domiciliary and nursing home care facilities, and the expansion, remodeling, or alternation of existing facilities.

In fiscal year 1991, the Secretary recognized new State homes at Murfreesboro, TN; Anderson, SC; LaSalle, IL; and Wilmore, KY. The Secretary is in the process of recognizing a 350-bed nursing home at Long Island, Stony Brook, NY, and an 83-bed nursing home at Silver Bay, MN. During fiscal year 1992, the Secretary expects to recognize State homes at Pocatello for 66 nursing home care beds and Roanoke, VA, for 240 nursing home care beds. The \$54.8 million obligated by VA in fiscal year 1991 for construction and renovation projects included new State homes at Daytona Beach, FL, for 120 nursing home care beds; Lewiston, ID, for 66 nursing home care beds; St. Louis, MO, for 200 nursing home care beds; St. Alban's in New York City, NY, for 250 nursing home care beds; Luverne, MN, for 83 nursing home care beds; a 126-bed nursing home addition at Charlotte Hall, MD; and a 204-bed nursing home addition at King, WI. Construction began on State homes in Roanoke, VA; Scranton, PA; and Pocatello, ID.

VA is developing programs which furnish pain management, supportive counseling, and other medical services to terminally ill veterans, as well as supportive and bereavement counseling to their families in various service settings. The hospice concept of care is generally being incorporated into VA medical centers' approaches to the care of the terminally ill. By FY 1993 all VA medical centers will be expected to provide a full range of hospice care.

HOSPITAL-BASED HOME CARE

The program provides in-home primary medical care to veterans with chronic illnesses in their own homes. The family provides the necessary personal care under the coordinated supervision of a hospital-based interdisciplinary treatment team. The team prescribes the needed medical, nursing, social, rehabilitation, and dietetic regimens, as well as providing the training of family members and the patient.

Seventy-five VA medical centers are providing hospital-based home care services. This program has made available more acute beds in hospitals by providing increased days of care in the home.

In fiscal year 1991 288,000 home visits were made by health professionals. Over 16,145 patients were treated.

ADULT DAY HEALTH CARE

Adult Day Health Care (ADHC) is a therapeutically oriented ambulatory program that provides health maintenance and rehabilitation services to veterans in a congregate setting during daytime hours. ADHC in VA is a medical model of services, which in some circumstances may substitute for nursing home care. VA continued to operate 15 ADHC centers in FY 1991. The average attendance was 437 and 1,144 patients were enrolled in fiscal year 1991. VA also continued a program of contracting for ADHC services at 24 VA medical centers. One hundred eleven contracts have been established. The average attendance was 153 and 739 patients were treated in fiscal year 1991.

COMMUNITY RESIDENTIAL CARE

The residential care home program provides residential care, including room, board, personal care, and general health care supervision to veterans who do not require hospital or nursing home care but who, because of health conditions, are not able to resume independent living and have no suitable support system (e.g., family, friends) to provide the needed care. All homes are inspected by a VA 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, at the veteran's own expense. Veterans receive monthly follow-up visits from VA health

care professionals. In FY 1991 an average daily census of 9,400 veterans was maintained in this program utilizing approximately 2,400 homes.

GERIATRIC EVALUATION AND MANAGEMENT PROGRAM

The Geriatric Evaluation and Management (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 4 to 20) on a Medical Service or an Intermediate Care ward of the hospital where an interdisciplinary health care team performs comprehensive geriatric assessments. 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 patients discharged from the hospital. In addition to improving care for older patients and preventing their unnecessary institutionalization, a GEM unit provides geriatric training and research opportunities for physicians and other health care professionals in the medical center.

Results from a controlled, randomized study of GEM efficacy that was conducted at the VA Medical Center Sepulveda, CA, showed significant benefits such as improved survival, decreased rehospitalization rates, improved functional status, and decreased nursing home placement following admission to the GEM unit.

Currently, 125 VA medical centers have established Geriatric Evaluation and Management Programs. Further expansion of the program is anticipated.

RESPIRE CARE

Respite Care is a program which provides planned, periodic, short-term care for a disabled person in order to temporarily relieve the caregiver from the physical and emotional burden of providing the needed care and supervision. VA provides respite care by admitting a veteran to a hospital or nursing home bed for up to 30 days a year. This institutionally based program not only supports the caregiver's role in caring for the veteran at home, but also provides an opportunity for VA staff to evaluate and treat the veterans health care needs and offer guidance to the caregiver in the home treatment plan. In FY 1991, 118 VA medical centers provided this care to veterans and their families.

ALZHEIMER'S DISEASE AND RELATED DISORDERS

VA's program for veterans with Alzheimer's disease and related disorders is decentralized throughout the medical care system with coordination and direction from the Office of Geriatrics and Extended Care. Veterans with these diagnoses participate in all aspects of the health care system including outpatient programs, acute care programs and extended care programs. Approximately 56 medical centers have established specialized programs for the treatment of these veterans.

Based on a survey conducted by VA in 1988-89, 31 facilities have inpatient dementia units, 22 have outpatient dementia programs, 25 have dementia assessment clinics and 8 facilities have established dementia registries. In order to advance knowledge about the care for veterans with dementia, VA conducts basic biomedical, applied clinical and health service research, much of which occurs at the Geriatric Research, Education and Clinical Centers (GRECCs), and which is supported through the Office of Research and Development. Rehabilitation Research and Development Service develops and evaluates new technologies and techniques designed to minimize excess disability associated with dementia. Continuing education for staff is provided through training classes sponsored by Regional Medical Education Centers, GRECCs and Cooperative Health Manpower Education Programs.

During FY 1990, VA disseminated education materials in the form of publications and videos to all medical centers. These included a revised edition of Guidelines for Diagnosis and Treatment of Dementia, a series of 21 Dementia Caregiver Education pamphlets developed by the Minneapolis GRECC, and 3 video tapes on Alzheimer's Disease developed by the Bedford Division of the Boston GRECC. During 1990 and 1991, VA surveyed a sample of medical centers with established inpatient units for patients with dementia. Information from this survey will be utilized for planning future programs, including specific educational needs of health care providers in the area of Alzheimer's Disease and related dementias.

GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTERS

The Geriatric Research, Education and Clinical Centers assume an important role in further developing the capability of the VA health care system to provide maxi-

mally effective and appropriate care to older veterans. First implemented in 1975, GRECCs are designed to enhance the system's capability in geriatrics by conducting integrated research, education and clinical care. The goals of the GRECCs are to develop new knowledge regarding aging and geriatrics, to disseminate that knowledge through education and training to health care professionals and students, and to develop and evaluate alternative models of geriatric care.

Each GRECC has developed an integrated program of basic and applied research, education, training, and clinical care in select areas of geriatrics. Current focal areas include cardiology; cognitive and motor dysfunction and neurobiology; endocrinology, neuroendocrinology, metabolism and nutrition; geropharmacology; immunology, oncology and infectious diseases; rheumatology; and molecular biology of aging. Using an integrated approach, the GRECCs are developing practitioners, educators, and researchers to help meet the need for training health care professionals in the field of geriatrics; providing information for as well as establishing models on cost-effective approaches to care of the elderly; and researching better methods to diagnose and treat health care problems of the older person as well as finding answers to fundamental questions on the process and consequences of aging.

At present there are 15 GRECCs. Twelve are fully operational and are located in VA medical centers at Ann Arbor, MI; Bedford and Brockton/West Roxbury, MA (2 divisions); Durham, NC; Gainesville, FL; Little Rock, AR; Minneapolis, MN; Palo Alto, CA; San Antonio, TX; St. Louis, MO; Seattle/American Lake, WA (2 divisions); Sepulveda, CA; and West Los Angeles, CA. Three new GRECCs began operation in FY 1991 at Madison, Miami, and Salt Lake City VA medical centers. Public Law 99-166, "Veterans Administration Health Care Amendments of 1985", increased from 15 to 25 the maximum number of facilities that the VA Administrator (now Secretary of VA) may designate for GRECCs.

III. OFFICE OF CLINICAL AFFAIRS

MEDICAL SERVICE

The Medical Service serves as the primary source of physicians for the care of elderly patients. Due to the aging of the population, the Medical Service is increasingly involved in all aspects of the delivery of health care to the aged. Acute and intermediate medical wards, coronary and intensive care units, nursing homes and outpatient clinics are all seeing an increased proportion of elderly patients with acute and chronic illnesses.

Some subspecialty areas are particularly impacted, including cardiology, endocrinology (diabetes), rheumatology, and oncology. The Medical Service provides necessary subspecialty care in inpatient and outpatient settings in addition to participating in Geriatric Fellowship Training, GRECCs, Geriatric Evaluation and Management (GEM) Programs, Hospice, Respite, and Hospital-Based Home Care. The specialized care that is required by the elderly has been recognized by Medical Service at approximately 25 VA medical centers, by their establishment of a Geriatric Medicine Section, which emphasizes clinical care, as well as coordinating research and education efforts related to geriatrics.

Age alone is less frequently used as a determinant of an individual patient's care. Geriatric patients increasingly undergo invasive diagnostic procedures. The Sunbelt is experiencing an increasingly heavy cardiac catheterization load, for example. The average age of patients treated in coronary and intensive care units is increasing, producing a concomitant demand for cardiac rehabilitation and physical fitness programs that are targeted to the frail elderly and the physically handicapped for all ages. Recently an oncology manual section was published which included as one of its goals, provisions of appropriate cancer care to elderly veterans. The special interest and involvement of Medical Service in geriatrics has also resulted in participation by internists in such programs as Adult Day Health Care, as well as in research problems in nutrition and treatment of hypertension.

Smoking cessation has been shown to benefit even elderly patients. Thus the role of Preventive Medicine for this patient population has expanded. The Medical Service has been active in implementing preventive strategies in smoking cessation, immunization (influenza and pneumococcal vaccines), and colorectal screening (for cancer).

The Medical Service has actively participated in the Intermediate Care Advisory Group and new guidelines for VA's Intermediate Care program were issued in Circular 10-89-132. Evaluation and treatment of elderly patients by interdisciplinary teams during intermediate-length hospital stays will be an increasingly important role for the physicians of the Medical Service.

SOCIAL WORK SERVICE

Social Work Service has placed increased emphasis on the development of a "Managed Care System" to address the special needs of older, chronically ill veterans who can be cared for most appropriately in the community. Implementation of managed care requires a rethinking and restructuring of our perceptions of patients; their health care requirements; VHA responsibility for ensuring availability of the medical-psycho-social health care continuum; resource configuration and deployment (personnel and facilities); graduate teaching affiliations; Medical/HSRD Research and VA/DoD Emergency Medical Preparedness. A system of managed care insures that patients receive the level of care appropriate to their illness/disability since quality of care cannot be achieved if patients are provided either more or less care than they require. It is also a resource management issue—to the extent that if acute or long term health care resources are "overutilized" they are unavailable for use by patients for whom they are clinically indicated.

Areas of social work practice central to a managed care system include Discharge Planning, Care Coordination/Case Management Services, and Community Services Coordination and Development. Social Work has placed national priority on these areas and a wide range of alternative care levels and service delivery models have been initiated and established across the system. While considerable progress has been made, much remains to be accomplished in expanding the understanding, commitment and service development necessary for preparing VHA and the Department for meeting the long-term care requirements of aging and other veterans requiring continued care services. Specific service development and program integration efforts are in place/and or under way in the following areas:

a. *At Risk Screening*—Automated or manual screening of patients at High Social Risk and requiring discharge planning and continuity of care services is operational systemwide.

b. *Discharge Planning Services*—Are well developed and available for patients requiring long term/continued care services, integration of VA/Community care systems and care coordination.

c. *Access to and Coordination of Community Services*—Social workers at all VA Medical Centers provide access to the community health and social service network for veterans who require continuing assistance to maintain an optimum level of health care functioning. Community Services Coordinators promote the coordination and delivery of services to impaired veterans and their caregivers, serve as the focal point of contact between the VA and the community service network and maintain a database of computerized information on available community services.

d. *Care Coordination/Case Management Services*—Care Coordination, or case management, is a service system in which the responsibility for assessing, planning, locating, coordinating, and monitoring groups of services rests with a designated provider and occurs on a case-by-case basis. Social work has implemented a comprehensive approach which maximizes utilization of veterans' multiple service eligibilities through linking together the interdisciplinary resources of our acute, intermediate, long-term care and veterans benefits programs with the full range of community health and social services to ensure integration and continuity of care for patients and their families. Already provided to significant categories of patients (long-term psychiatric, visually impaired, spinal cord injured, dialysis, ex-POW's, Adult Day Health Care (ADHC), Hospital Based Home Care (HBHC), Hospice, etc.), Care Coordination Services must be available to all patients requiring such services if VHA is to ensure clinically relevant care, continuity, and cost effectiveness. Social Work is expanding care coordination services within primary ambulatory care settings and has developed software which will provide tracking, monitoring, and support for a systemwide program of VA/Community participation and accountability in this important area. We continue joint planning efforts with Area Agencies on Aging (AAAs) and community health and welfare councils/planning bodies to establish and expand community based case management and support services for elderly/infirm veterans and members of the larger community.

A national training initiative is in process to provide training of an interdisciplinary team from each medical center to address this CMD Strategic Planning Initiative. "Alternative Levels of Care: Completing the Health Care Continuum" has been provided within Region 3, half of Region 2 and is scheduled for nationwide completion during FY 94.

The Community Residential Care Program (CRCP), VA's oldest and most cost effective long-term care program, has been in existence since 1951. The CRCP is within the Office of Geriatrics and Extended Care (see p. 9) but is directly managed and coordinated by Social Work Service at 127 VA Medical Centers. This alternative

level of care program provides supportive health care service to approximately 9,500 older, chronically ill veterans who otherwise would occupy acute or nursing care beds in VA or the community or would be homeless. Emphasis is being placed on the expansion of this program to all VA medical centers in response to the growing demand for options to institutional care for veterans who can be cared for more appropriately in the community.

In addition, many of VA's funded community programs for older veterans have the potential for reconfiguration in response to the changing health care needs of a population that cannot be served through VA's institutional programs alone. A funded demonstration project is underway at one VA medical center using a managed care approach in the coordination and integration of VA and community services for older veterans who are high consumers of VA resources. This project will be expanded to three additional VA medical centers in other geographical areas and is scheduled for completion in 1995. Consistent with the need to better coordinate services and programs in the Federal sector, a Regional Coordinating Council has been established under VA leadership in the Southwest involving representation from Indian Health Service, Bureau of Indian Affairs, tribal officials in addition to key VA staff in New Mexico and Arizona. The Council is addressing issues of access to health care and other services and is promoting joint efforts to improve services to Native Americans, including the elderly.

Clinical experience over the past several years has confirmed that treatment and continued care of chronically impaired veterans must include the family caregiver. National studies have consistently found that as high as 80 percent of patients meeting criteria for admission to skilled nursing homes are cared for at home by elderly spouses and/or children. While recognized as primary and legitimate care providers in such programs as Respite, HBHC, Hospice and ADHC, the early identification and involvement of the primary caregiver as an active participant on the health care team and investment in their education and training are critical for support of their caregiver role and the future integrity of VHA.

Social work has drawn from established caregiver support programs at three medical centers in developing staff training and caregiver teaching materials for system-wide use. We have also initiated efforts to identify and train additional personnel to provide caregiver services.

Community based volunteers are a largely untapped resource for assisting clinical staff in sustaining patients in community settings. Experience of Senior Companion Programs at over 30 VAMCs, the Older Veterans Assistant Program (OVAP) sponsored by DAV, and a wide range of community participation by organized veterans groups and affiliated volunteers has demonstrated the crucial role volunteers contribute to both patient and primary caregiver.

Volunteers live in the veterans community, know and understand the service networks and can provide/mobilize resources critical to sustaining veteran patients in their own homes. Social Work and Voluntary Services have undertaken a joint initiative to recruit and equip this valuable resource for the continued treatment and community stabilization of veteran patients and caregivers.

REHABILITATION RESEARCH AND DEVELOPMENT

The mission of the Rehabilitation Research and Development (Rehabilitation R&D) Service is to "support research for improving the quality of life of impaired, disabled and handicapped veterans, including our aging veterans." This is accomplished by conducting a program of research, development and evaluation of new and unique devices, techniques and concepts of rehabilitation that will allow more functional independence in the activities of daily living of physically disabled and infirm veterans.

The Rehabilitation R&D Service has established a significant interest area in the field of aging. The Rehabilitation R&D Service will actively promote this effort through the following:

- Stimulate new R&D in VA Medical Centers to meet the needs of disabled aging veterans.

- Support a Rehabilitation Research and Development Unit at Decatur, GA, whose primary focus is the needs of aging veterans.

- Evaluate in VA medical centers newly developed devices, techniques, and concepts on rehabilitation as they pertain to the aged.

- Promote commercialization of the products of VA-sponsored R&D.

Promote the utilization of rehabilitation R&D technological advances developed by our research and that of others by dissemination of the *Journal of Rehabilitation Research and Development* and articles in other professional journals.

In addition to the Rehabilitation R&D unit at Decatur, GA, specializing in aging and merit-reviewed projects at VAMC's throughout the Nation, Rehabilitation R&D supports two other Rehabilitation R&D Centers which conduct research impacting on aging.

One of these centers is located in Palo Alto, CA. In collaboration with Stanford University, this center conducts research in orthopedic, biomechanics, and man-machine integration as it is related to robotics, and analytic modeling of disability and devices. Another center is located at Hines, IL, with research emphasis in orthopedic surgery and visual deficiencies.

One of the unique problems that the elderly experience is that of mobility. Wheelchairs provide mobility for the elderly. In the early 1940's the wheelchair was revolutionized with the design and manufacture of a portable, lightweight, strong, and maneuverable model. Since then the most important innovation has been the powered chair. Rehabilitation R&D has been supporting several efforts to make wheelchairs more useful to those who need them. We have supported the development of standards for wheelchair manufacture and design and these standards have been submitted to and accepted by the American National Institute of Standards. There are approximately 125 wheelchair manufacturers in the United States today, each making a variety of models.

Three major problems which wheelchair users experience are:

- (1) the inability to make the wheelchair go when one or both arms of the individual lacks strength or function to operate the wheelchair;
- (2) to make the wheelchair go sideways or kitty-cornered as well as forward and backward; and
- (3) to surmount the barriers of stairs, curbs, and uneven terrain.

The Rehabilitation R&D Center at Palo Alto, CA, has developed an Ultrasonic Head controlled wheelchair. In this design, head movements of the patient activate two polaroid ultrasonic distance ranging sensors which generate control signals for the operation of the chair. This device is now being clinically evaluated. Another researcher at Palo Alto is working on an Optimal Biomechanical Design for the Development of an Arm Powered Mobility Vehicle. The thrust of this work is the search for the most mechanically efficient method of powering wheelchairs with the upper extremities. Another design out of Palo Alto, now commercially available is the omnidirectional wheelchair which can move in any direction.

A very sophisticated kind of environmental control which has relevance to the needs of older persons is the family of robotic arms—articulated metal arms that can be programmed for some basic function. The robot can be useful for assisting in eating, grooming, reaching for a book, turning a page or summoning an attendant. Some respond to voice commands. The Rehabilitation R&D Service is in the process of commercializing the first generation of robotic arms for use with quadriplegics—who are enthusiastic about the degree of independence robotic arms provide. Research is being conducted to establish the man-machine interface for older persons.

The Rehabilitation R&D Unit in Decatur, GA, is pursuing research in the care of individuals who are demented, particularly those with dementia of the Alzheimer's type. Wandering is a serious problem for both caregivers and elderly persons who engage in the behavior. Another major problem affecting the elderly is falls. The Decatur unit has several research projects funded which will establish relationships between falls, balance, sensory loss, and muscle weakness within the aging population.

It is hoped that these studies will produce diagnostic indicators for patients at risk and assess the effectiveness of computer automated balance training.

The Rehabilitation R&D Service is in the process of digitizing hearing aids. One of the problems that hearing aid wearers face is the inability of the clinician to adjust the hearing aid to the specific and unique characteristics of the wearer. Rehabilitation R&D is supporting research that is approaching commercialization on the digitized hearing aid. This important development involves the use of a computer to fine tune the hearing aid to the specific hearing loss frequencies of an individual.

REHABILITATION MEDICINE SERVICE

Rehabilitation Medicine Service (RMS) strives to provide all referred older persons with comprehensive assessment, treatment, and follow-up care for psychosocial and/or physical disability affecting functional independence and quality of life. Through the use of physical agents, therapeutic modalities, and exercises, rehabilitative therapists assist the patient in developing and attaining specific goals.

Approximately 24,000 veterans per year are treated and discharged in over 1,400 RMS beds at 75 medical centers. Growth rate of 8 percent in the number of RMS

beds is forecast for the next 5 years. Physicians, usually physiatrists, lead teams of therapists and other interdisciplinary professionals.

Occupational therapists, physical therapists, along with kinesiotherapists and other rehabilitation professionals are leading and participating in innovative treatment, clinical education, staff development and research in homebound health care, independent living centers, Geriatric Evaluation and Management Units, Alzheimer Adult Day Health Care, Day Treatment Centers, domiciliaries, interdisciplinary team training, Geriatric Research, Education, and Clinical Centers, and hospice care programs. Funded educational opportunities are available for occupational and physical therapists and physicians in Interdisciplinary Team Training Programs (ITTPs) and for occupational therapists in GRECCs.

Handicapped driver training centers are staffed at 39 VA medical centers to meet the needs of aging and disabled veterans. Classroom education, updates in laws, and defensive driving techniques are supported with behind-the-wheel driver observation from driver training professionals.

A uniform assessment tool, the uniform Functional Independence Measure (FIM) is being implemented throughout the VA rehabilitation system. Therapists are trained to apply an 18 element functional measure at the time of admission, regularly during treatment and at discharge. Application of FIM results to quality management activity will assist local and national rehabilitation clinicians and managers to maximize effective and efficient rehabilitation care delivery. An administrative data base called the Uniform Data System for Medical Rehabilitation will increase accuracy of developing predictors and ideal methods of treatment for veterans with various diagnoses.

NURSING SERVICE

Nursing care of the elderly veteran is a vital part of the Nursing Service mission and comprises the largest proportion of health services required by this age group. Recognizing the rapid increase in the number of aging veterans being admitted for care in all treatment modalities, Nursing Service is making a concerted effort to provide strong leadership in the clinical, administrative, research, and educational components of nursing practice.

Academic preparation is a high priority of Nursing Service to assure quality programs for treatment and rehabilitation of aged ill, disabled and at-risk veterans. Graduate nursing students receive clinical education experience in Geriatric Evaluation and Management (GEM) Programs, Nursing Home Care Units (NHCUs) and Hospital-Based Home Care (HBHC) programs. While the demand for rehabilitation nurse specialists has been increasing, the supply has been diminishing over recent years, due primarily to the nursing shortage and the reduction in nurse traineeship funds for graduate education in this specialty area. Sixty-three positions in 46 (VA Medical Centers) were funded in 1990 by the Clinical Nurse Specialist Program for masters level nursing students in either geriatric/gerontological, rehabilitation or psychiatric/mental health nursing. Forty-eight were funded in these areas in 1991. Sixteen were funded in geriatric/gerontological nursing, one in rehabilitation nursing and 31 in psychiatric/mental health nursing.

Recruitment of highly qualified professional nurses is an on-going priority. Executive development of nurse leaders in long-term care is provided through preceptorship training for the position of Associate Chief or Supervisor, Nursing Home Care. Currently, 40 Supervisors of Nursing Home Care have been approved for the discretionary title of Associate Chief, Nursing Service for Nursing Home Care. Preventive care and health promotion incentives are implemented to preserve independence, foster productivity, and enhance the quality of life by improving the health status of aging veterans. Proper screening, education, and referral of elderly veterans are vital to meeting their health care needs. The "young old," ages 65-74 are relatively healthy and concerned with maintaining their health and independence. Nurses in wellness clinics and other ambulatory care settings provide supervision, screening and health education programs to assist veterans in maintaining healthy life styles.

Nurses play a key role in restoring functional abilities of aging veterans with chronic illness and disabilities. Programs for the physically disabled and cognitively impaired have been established and are administered by nurses in home care, ambulatory care settings and inpatient units. Treatment programs are goal-directed toward physical and psychosocial reconditioning or retraining of patients with biological and psychosocial disturbances. Patient and family teaching is a major part of each program. Family and significant others have a key role in providing support to aging veterans and are assisted in learning and in maintaining appropriate caregiver responsibilities. VA nurses contribute to planning and implementing health care services for the elderly in the community-at-large. They participate in self-help

and support organizations related to specific diseases such as Alzheimer's, are advisors to local health planning councils, and share VA educational activities and research seminars with other health care professionals.

While progress has been made in the care of aging veterans, increasing demands, shortages of critical health care personnel, and cost-containment issues require more effective coordination of health care delivery to prevent fragmenting of care and inappropriate institutionalization. Nursing participated in an interdisciplinary task force established to address the issues of providing continuity of care. Practice models are needed to facilitate the care of aging veterans throughout the health care continuum and to assure access to the appropriate level of care in the most cost-effective setting. Professional nurses function as part of interdisciplinary teams to coordinate and provide care in settings beginning with GEM programs and progressing along many care settings including ambulatory care, acute care, intermediate care, long-term care and community agencies. An interdisciplinary program, "Discharge Planning for Continuity of Care" emphasizing the unique problems of the elderly was presented to a cluster of medical centers in Region I and is planned for a second group. Continuing education is essential to assure all levels of staff have knowledge and skills to meet needs of this rapidly growing age group. Nursing was part of several national task forces responsible for national training programs focused on improving the quality of health care for aging veterans. These programs included:

"Health Care Problems of the Elderly" was presented in one region for eight medical centers to an interdisciplinary team composed of seven disciplines. Members of the task force continue to serve as consultants to interdisciplinary teams in all medical centers who have attended this program to assure that plans are implemented and care to aging veterans is evaluated.

"Ambulatory Care of the Elderly" was presented in 1 region for interdisciplinary teams in 35 VA medical centers and 4 outpatient clinics. The focus of this program was proper assessment, screening, referrals, and coordination of care in the ambulatory care settings. This program is planned for VA medical centers in the Northeast in June 1992.

"Long Term Care of the Mentally Ill," was presented for interdisciplinary teams from 15 nursing home care units. The program is planned for VA medical centers in the Western Region in May 1992.

Phase I of the interdisciplinary program to improve the quality of life for aging patients in VA nursing homes is completed. Pilot programs at Dallas and Washington VAMCs accomplished the goals to reduce the number of medications used by nursing home patients, improve their functional status and enhance the satisfaction of staff working in Nursing Home Care Units. A bran study at both sites decreased the use of laxatives and saved nursing time. The Washington project demonstrated that adding fiber to the diet of nine veterans requiring laxatives or other preparations saved 7.5 hours of nursing time per week.

Fifteen staff representing 10 disciplines participated in the Washington pilot. The treatment team consisting of physician, nurse, and clinical pharmacist focused on the appropriate use of medications. Since the project began there has been a significant reduction in the cost and number of medications prescribed in NHCU patients. Other disciplines focused on psychosocial support, spiritual expression, recreation, exercise, and socialization. Each program/activity contributed to the quality of life of aging veterans. Group activities provided opportunities for patients to become better acquainted with each other resulting in increased socialization. Patients are more involved in their care and better able to manage their chronic illness or disability. A significant collateral benefit of this project has been increased collaboration among the interdisciplinary team with the positive outcome of enhanced continuity of care. There has also been an increase in the use of the NHCU as a clinical site for professional students (medical, nursing, social work, and psychology) who are attracted to the innovative team approach. There have been numerous opportunities for the interdisciplinary team to present the pilot program at professional meetings and seminars.

The remaining 124 VA nursing home care units will be given the opportunity to participate in phase II of this project. Guidelines for participation in phase II are being finalized by the VACO steering committee.

Professional nurses are encouraged and supported in their efforts to conduct research, especially in clinical settings. Research is needed to advance health care for older persons and to improve gerontological nursing practice. Areas in which research is urgently needed to improve the quality of care include:

- Urinary incontinence
- Falls

- Care of Alzheimer's patients
- Wandering behavior
- Dementia
- Nutrition
- Exercise
- Mobility
- Psychotropic medication
- Health promotion
- Frail elderly in the home setting
- Alternatives to institutional care

As the number of female veterans increases, studies are needed to enhance the quality of life for aging female veterans in a health care system largely focused on the male model of care. Timely application of research findings to clinical care in all practice settings will improve the quality of care to aging veterans.

DIETETIC SERVICE

Dietetic Service has been involved this past year in several national efforts addressing the nutritional care of older veterans. Since July our elderly patients with swallowing or chewing difficulties are testing 61 powders developed by the Food Engineering Directorate at the U.S. Army Natick Research and Development Laboratories. When the powders are reconstituted into a liquid or puree, they taste like components of a normal meal. Eight of our medical centers are participating in this 6-month study. They are evaluating the appearance, flavor, consistency, texture, ease of sipping, variety, portion size and overall acceptability of a 5-day menu of liquid products. Dietitians are comparing the nutrient intakes and changes in patient's weight for those using the Natick foods and those consuming the current dental liquid diet. They are also evaluating and comparing the preparation time and ease of preparation of Natick products with those normally served at their Center.

VA dietitians are actively participating in the American Dietetic Associations' American Academy of Family Physician's, and National Council on Aging's National Screening Initiative. This project was launched on May 22, 1990 as a 5-year, multifaceted effort to promote routine nutritional assessments and better nutritional care. The initial focus is the elderly. A consensus paper on the nutritional needs of the elderly led to the development of three assessment screens: (1) public awareness; (2) preliminary screening in senior community health programs; and (3) screening in physician's offices and other health care settings. Individuals with high scores on the screen have been shown to have high mortality rates. The screening instrument for public awareness is being pilot tested by the New England Research Institute for validity. A test is being designed to validate the other screens over the next 1-2 years.

A joint project we share with other services is The National Training Program on Health Care Problems of the Elderly. This program promotes multidisciplinary care to improve the quality of care. A conference was held in Denver this year. Each medical center attending the conference developed an action plan. These plans will be followed-up by the trainers for the next 2 years. A satellite broadcast program on future directions of geriatrics and extended care in the VA was also produced this past quarter.

Determining the nutritional care needs and developing a care plan to achieve these goals is very complex when managing an older person. In order to concentrate efforts on this large segment of our population, Geriatric Nutrition Specialist positions will be released soon. Staffing guidelines for Dietetic Service in nursing homes were revised and field tested this year. Several standards have also been developed to ensure quality care of our elderly. Former region 7 dietitians have developed Nutrition Care Standards for Long Term Care Geriatric Patients. Currently they are developing guidelines (including references) for each standard. Together with other health professionals, these dietitians are also developing several clinical indicators to assure that the patient not only receives his food but is fed. These indicators will be field tested prior to national dissemination.

IV. OFFICE OF DENTISTRY

Dentistry has traditionally been a rather isolated, clearly defined health discipline. Its professional obligations and responsibilities often have been conducted without substantial regard to the activities of other health care providers. However, as the age of dental patients reaches into the seventh, eighth, and ninth decades, this style of service and the priorities of care must undergo dramatic shifts. For the geriatric patient, dentistry's first priority is the alleviation of pain and suffering at

tributable to oral disease or dysfunction. Providing patients with a safe, comfortable, and effective mechanism for eating, while simultaneously giving them access to a wide variety of foods, promotes patient well-being and hastens convalescence after surgery, chemotherapy, and other major medical treatments. Interpersonal skills, highly dependent upon physical appearance and effective communication, can be enhanced by improving the shape, texture, and color of front teeth, or by replacing the visibly missing teeth, or providing underlying support to the external perioral tissues. Clarity of speech can be sharpened by proper positioning of front teeth, in relationship to the lips and tongue. The goals of these services are consistent with those of all disciplines involved in geriatrics—maximize functional performance, foster independence in living, and prudent use of scarce resources. Dentistry should be an integral part of any comprehensive health care program for the elderly.

The nature of dental disease in late life—chronic, asymptomatic even in advanced stages, aggravated by coexistent medical problems, and perceived as a low priority by health funding agencies—calls for an increased emphasis on preventive services. Individual, often very complex preventive dental programs, are customarily designed for each patient. This may include the use of home applied fluoride solutions, antimicrobial mouth rinses, specially fabricated tooth brushes, instruction to family or other care givers on oral hygiene techniques, and more frequent dental examinations. These low-cost low-tech measures obviate the need for expensive or invasive dental care in the future. VA has been a world leader in developing preventive dental therapies and testing them in the clinical setting for proven efficacy.

Oral cancer, one of the most disabling and physically disfiguring diseases is primarily a problem of the elderly. Alcohol consumption, use of tobacco, and age are the three most significant factors in the etiology of oral cancer. It is only through early detection, generally in the asymptomatic stages, that effective treatment can be instituted. Through a program of offering oral screening examinations, VA dentists have identified oral cancers in the incipient phases well within the range of treatment, sparing many older veterans from long term swallowing and eating difficulties and, in some instances, actually saving lives.

As of 1990, 93 VA medical centers had established Geriatric Evaluation and Management (GEM) programs. At each facility, dentistry is contributing to the team effort—conducting admission oral examinations, collaborating on interdisciplinary treatment planning, providing specialty consultations, and preparing summaries of the course of care for discharge. These examinations have identified problems, previously undetected, that have documented negative effects on chewing efficiency, safe swallowing, and clear speech. Interdisciplinary treatment planning takes advantage of the synergy associated with the group effort. Patients rehabilitate more rapidly with properly staged and coordinated care. Unexpected outcomes of another discipline's therapies or newly exposed problems often warrant urgent specialty consultation. For matters involving the oral dental complex, dentistry has responded with timely assessments, definitive diagnosis, and recommended treatment. And at discharge, review of the patient's response to treatment, plan for maintenance, and guidance for future care are prepared. The GEM Program has been an ideal environment for dentistry to demonstrate its relative worth and range of contributions to the interdisciplinary team.

"Health Care Problems of the Elderly", a VA National Training Program (NTP) initiated in 1988, has advanced the philosophy and value of interdisciplinary care throughout the system. Emphasizing a need for individual discipline expertise to identify and sort out the multifarious problems of the elderly has been a hallmark of this NTP. From the initial planning stages, dentistry has participated in this project, recommending educational content, format of training, and faculty selection. Having been acknowledged as a vital discipline within geriatrics, dentistry was a member of the core faculty and had representation from every medical center invited to participate in the regional workshops. Arlington, VA, Northport, NY, and Minneapolis, MI, have served as the training sites for this NTP. A spring 1992 meeting is scheduled for Nashville, TN. Forty-four individual VA medical centers will have benefitted from this experience, sharing knowledge and devising new strategies in caring for the older veterans.

Developing discipline-specific training in Dental Geriatrics is a major goal of the VA Dental Education Centers (DECs). With support and funding from the Minneapolis Regional Medical Education Center, a national network of collaborative education programs in geriatric dentistry was organized. Capitalizing on the resources, special expertise, and facilities of the VA's DECs, Regional Medical Education Centers (RMECs), Geriatric Research Education and Clinical Centers (GRECCs), and the Continuing Education Field Units (CEFUs), continuing education programs throughout the country have been planned. In addition, clinical topics in geriatrics have

been integrated into the traditional education programs offered by the DECs. This integration will reinforce the need for full Service participation rather than relegating the care of older veterans to a select few.

With the changing profile of veterans residing in nursing home care units (NHCUs) and the projected expansion of the capacity of these units by 50 percent over the next 5 years, new and additional demands will be placed on VA Dental Services. The increased technical complexity of "dental procedures" needed by NHCU patients is often aggravated by concurrent medical and psychosocial problems. To prepare VA Dental Services to meet the challenges posed by a new generation and exploding population of NHCU residents, an NTP for VA dental staff serving NHCUs is in preparation. This educational experience clearly identifies priorities, the goals of the Dental Service when caring for NHCU residents, and the resources available to meet these needs. All VA medical Centers with NHCUs will be invited to participate in a 3-day workshop. General sessions, examining prevalent medical and psychosocial disorders known to complicate oral health, the diagnosis of oral disease, dental treatment, and oral hygiene maintenance, will be the main foci of the conference. Discipline-specific topics in dentistry, dealing with new technologies available to provide safe and expeditious care, complement the general sessions. Discussion sessions have been planned so that participants will have an opportunity to debate ethical issues in treatment decisions. Finally, an exhibit of table clinics and posters is proposed for those VA dental staff interested in presenting programs, projects, treatment procedures, or other matters in patient care that have been developed and successfully employed at their individual medical centers. This mix of educational experiences will underscore the complexity and diversity of the oral health problems of veterans residing in nursing home care units. Furthermore, this NTP will serve as a forum for sharing of professional knowledge while simultaneously striving for consistency in the quality of care throughout the VA health care service. The VA Program Guide: *Oral Health Guidelines for Long Term Care Patients*, developed several years ago by the Office of Dentistry, continues to serve as the primary handbook for management of the multidisciplinary efforts.

The VA Dental Geriatric Fellowship Program has proven to be an excellent recruitment source for dentists who have been uniquely trained in the care of the elderly. A significant number of these graduated fellows currently serve as staff dentists throughout the VA system. Their activities not only have had a direct bearing on the patient care and other geriatric initiatives within the facilities which employ them, but they also have contributed to the geriatric efforts ongoing at nearby VA facilities, at affiliated universities and in the community in general. They also have participated in a number of studies which surveyed the oral health status of various aged populations and addressed the present and future manpower and other resource needs. For instance, two former geriatric fellows are currently studying the oral health care needs of VA Hospital-Based Home Care (HBHC) patients.

The VA impact on geriatric dentistry is not limited to its own health care system, but extends to the national scene as well. VA dentists regularly participate in the National Institute for Dental Research (NIDR) group that is involved in reviewing oral health promotion and disease prevention initiatives throughout the country and also have been represented on a U.S. Surgeon General's workshop relating to the same topic. In education, the American Association of Dental Schools, (AADS) has an ongoing Geriatric Education Project. Its goal is to enhance the quality of dental services that are available to older people in the United States by improving the teaching of geriatric dentistry in dental and dental hygiene schools. VA dentists participate, playing a major role, in the working committees formed to design curriculum and identify resource material for faculty utilization.

V. HEALTH SERVICES RESEARCH AND DEVELOPMENT

Health services research and development (HSR&D) is an area of research designed to enhance veterans' health by improving the quality and cost effectiveness of the care provided by the Department of Veterans Affairs. The focus of VA HSR&D is on (1) advancing the state of knowledge about health services in VA and the Nation and (2) disseminating that knowledge for practical use. The large number of aging veterans and their increasing health care needs make this population particularly important for HSR&D to study. Each of the Service's three major areas emphasized aging during 1991.

(1) *The Investigator Initiated Research (IIR)* program encourages and supports projects proposed and conducted by VA researchers, clinicians, and administrators from throughout the Nation. In this intramural program of health services R&D, VA staff conduct merit reviewed and approved projects in VA Medical

Centers with oversight and advice from Central Office. The IIR program comprised 39 percent of the 1991 HSR&D budget.

Forty-eight percent of the 63 HSR&D investigator initiated projects addressed questions important to aging veterans. New projects during this past year include studies of the determinants of health service use after nursing home care, the use of telephone intervention with elderly diabetes patients, and nutritional programs for the hypertensive elderly veteran. Ongoing investigations include studies of the management of Alzheimer patients, an emergency response system for at-risk veterans, the impact of computerizing medical records on elderly outpatients, and the predictors of adverse outcomes in hospitalized elderly patients. The 22 research projects completed during 1991 included studies of geriatric rehabilitation and of the cost-effectiveness of post-discharge care for the elderly.

(2) The HSR&D *Field Program* is a network for core VA staff assigned to selected medical centers. Staff conduct independent research and collaborate with community institutions in support of program objectives. In 1991, the Service funded eight ongoing HR&D Field Programs encompassing 26 medical facilities. Field Programs comprised 33 percent of the 1991 HSR&D budget.

The Field Programs serve as centers of excellence in selected subject areas. While all Field Programs have an interest in the health care issues of aging, three make aging their primary focus. The Northwest Field Program at the Seattle VAMC continues to provide leadership in the care of aging veterans. The Midwest Field Program at Hines VAMC in Illinois emphasizes gerontology and rehabilitation. The recently established Bedford VAMC program in Massachusetts is a Center for Health Maintenance for Aging Veterans. Field Programs foster the integration of research and practice by VA managers and clinicians. They also link research with local patient care and administrative needs. The Field Programs have trained more than 80 pre-doctoral students and produced approximately 1,400 publications and 1,000 presentations.

Field Program investigations during 1991 included studies of the effects of social support on the mental health of the elderly, foot care among elderly diabetics, the effectiveness of behavioral treatment for insomnia, and the outcomes of CPR administration to the elderly.

Two Field Programs were expanded in 1991 to incorporate the new Centers for Cooperative Studies in Health Services Research. These centers provide the planning and coordination for multifacility studies in health services research. Because of its size, complexity, and data availability, the VA health care system offers a unique opportunity to conduct such large scale research. The opportunity to do this is now being enhanced by combining the existing Cooperative Study Program (biomedical research) and HSR&D Field Program experience, skills, and expertise. The resulting studies' anticipated use of common protocols and data sets is expected to yield more definitive findings than may be available in other health care research environments. Among the projects being developed as Cooperative Studies in Health Services during 1991 were studies of geriatric evaluation and management units.

(3) The *Special Projects* program conducts research assessment, syntheses, and other special research projects responsive to specific needs identified by Congress or Department officials and assists in transforming health services research into practice. This is a centrally directed program of health services R&D conducted by VA field staff, in-home staff, and/or contractors engaged to solve specific problems. In 1991, Special Projects comprised 28 percent of the HSR&D budget.

A major evaluation of the effectiveness and costs of Adult Day Health Care (ADHC) was completed for Congress this year. This study consisted of two components. The first involved a randomized controlled trial to evaluate VA ADHC in comparison with the usual VA care.

The second component involved an evaluation of the cost-effectiveness of ADHC relative to similar care provided by community agencies under VA contract. The results of this study have implications for costs, contract services, and the targeting of patient populations.

Other special project investigations underway during 1991 included the Normative Aging Study, which is a major long-term study of the normal process of aging, and a study of bereavement among spouses of veterans who die while under the care of the VA health care system.

During 1991 HSR&D activities related to aging also included the publication of a special issue of the *Journal of the American Geriatrics Society* that resulted from a conference on Geriatric Evaluation Management Units sponsored by VA HSR&D

Service, the Robert Wood Johnson Foundation, and the National Institute on Aging. Planning also was begun for a 1992 conference on ambulatory care services for elderly veterans. Finally, a new Career Development Awards program was initiated in 1991 to stimulate research careers among VA clinicians. Among the investigations being conducted by the first award recipients is a study of the effect of physical therapy on nursing home residents.

VI. OFFICE OF ACADEMIC AFFAIRS

All short- and long-range plans for VHA that addressed health care needs of the Nation's growing population of elderly veterans include training activities supported by the Office of Academic Affairs (OAA). The training of health care professionals in the area of geriatrics/gerontology is an important component in a variety of programs conducted at VA medical centers in collaboration with affiliated academic institutions. Work with geriatric patients is an integral part of the clinical experience of the nearly 100,000 health trainees including 30,000 resident physicians and 40,000 nursing and associated health students who train in VA medical centers each year as part of affiliation agreements between the VA and nearly 1,000 health professional schools, colleges, and university health science centers. Recognizing the challenges presented by the ever increasing size of the aging veteran population, the OAA has made great strides in promoting and coordinating interdisciplinary geriatric and gerontological programs in VA medical centers and in their affiliated academic institutions.

The Office of Academic Affairs, in the VHA, supports geriatric education and training activities in the following special programs:

VA FELLOWSHIP PROGRAMS IN GERIATRICS FOR PHYSICIANS AND DENTISTS

Geriatric Medicine

The issue of whether or not geriatrics should be a separate medical specialty or a subspecialty was resolved in September 1987 when the Accreditation Council for Graduate Medical Education (ACGME) approved Geriatric Medicine as an area of special competence. Effective January 1988, the American Board of Internal Medicine and the American Board of Family Practice specified procedures for the certification of added qualifications in geriatric medicine. VA played a critical role in the development and recognition of geriatric medicine in the United States, and as of AY 1989-90, any VA medical center may conduct fellowship training in geriatrics, providing an ACGME accredited program is in place.

The demand for physicians with special training in geriatrics and gerontology continues unabated because of the rapidly advancing numbers of elderly veterans and aging Americans. The VA health care system offers clinical, rehabilitation, and follow-up patient care services, as well as education, research, and interdisciplinary programs that constitute the support elements that are required for the training of physicians in geriatrics. Since 1978-79 this special training has been accomplished through the VA Fellowship Program in Geriatrics conducted at VA medical centers affiliated with medical schools. The 12 initial training sites increased to 20 in 1986 and to 33 in 1991.

These fellowships are designed to develop a cadre of physicians who are committed to clinical excellence and to becoming leaders of local and national geriatric medical programs. Their dedication to innovative and thorough geriatric patient care is expected to produce role models for medical students and for residents. The 2-year fellowship curriculum incorporates clinical, pharmacological, psychosocial, education, and research components that are related to the full continuum of treatment and health care of the elderly.

During its 13-year history, the program has attracted physicians with high academic and professional backgrounds in internal medicine, psychiatry, neurology, and family practice. Their genuine interest in the well-being of elderly veterans is apparent from high VA retention rate after completing the fellowship training. Many of the fellows have published articles on geriatric topics in nationally recognized professional journals, and several Fellows have authored or edited books on geriatric medicine and medical ethics. The number of recipients of imported awards and research grants (AGS/Pfizer, AGS/Merck, Kaiser, NIA, and VA) increases each year.

As of June 1991, 275 Fellows had completed the program in 11 successive groups: 1980-8; 1981-12; 1982-16; 1983-19; 1984-23; 1985-22; 1986-27; 1987-23; 1988-28; 1989-27; 1990-28; and 1991-41. About 45 percent remain in the VA system as full or part-time employees. Close to 50 percent of all graduates held aca-

demic appointments. The VA group of 275 fellowship alumni/ae represents the largest single agency contribution to the pool of trained geriatricians in the United States.

Geriatric Dentistry

In July 1982, 2-year Dentist Geriatric Fellowship Programs commenced at five medical centers that are affiliated with schools of Dentistry. The goals of this program are similar to those described for the Physician Fellowship Program in Geriatrics. As of June 1991, 40 Dentist Fellows had completed their special training. In 1988, the number of training sites increased to six for a final 3-year cycle. About 75 percent of the program alumni/ae have accepted offers of post fellowship employment in the VA system.

The format of these fellowships, however, has changed from predesignated sites to individual awards. Candidates from any VA medical center with the appropriate resources may compete for postdoctoral fellowships for dental research. To date, six fellows have completed successfully and started their training in July 1991.

Geriatric Psychiatry and Geriatric Neurology

In 1990-91, the Department of Veterans Affairs established a 2-year Fellowship in Geriatric Psychiatry to develop a cadre of physicians with expertise in two areas:—specialized knowledge in diagnoses and treatment of elderly patients with dementia and other psychiatric problems.

—innovative teaching and research skills for academic potential.

The first competitive review in 1990 selected 8 VA medical centers that are affiliated with U.S. medical schools as training sites for these fellowships. The second review, in 1991, added one more site for geriatric psychiatry and established 4 sites for geriatric neurology. Eleven fellows entered this special training in July 1991.

The American Board of Psychiatry is currently developing criteria for ACGME accredited training in geriatric psychiatry. Until this accreditation process becomes official, VA experts to provide funding for fellow level training at selected sites. This is another example of VA's initiative in establishing programs in areas of need. Upon activation of the ACGME process, VA fellowship programs will be in a position to serve as models for others.

Interdisciplinary Team Training Program

The Interdisciplinary Team Training Program (ITTP) is a nationwide systematic educational program that is designed to include didactic and clinical instruction for VA faculty practitioners and affiliated students from three or more health professions such as physicians, nurses, psychologists, social workers, pharmacists, and occupational and physical therapists. The ITTP provides a structured approach to the delivery of health services by emphasizing the knowledge and skills needed to work in an interactive group. In addition, the program promotes an understanding of the roles and functions of other members of the team and how their collaborative contributions influence both the delivery and outcome of patient care.

The ITTP has been activated at 12 VA medical centers. Two sites located at VA Medical Centers (VAMCs) Portland, OR, and Sepulveda, CA, were designated in 1979. Three additional VA sites at Little Rock, AR; Palo Alto, CA; and Salt Lake City, UT, were selected in 1980; and VAMCs Buffalo, NY; Madison, WI; Coatesville, PA; and Birmingham, AL, was approved in 1982. In the spring of 1983, three sites were selected at VAMCs Tucson, AR; Memphis, TN; and Tampa, FL.

The purpose of the ITTP are to develop a cadre of health practitioners with the knowledge and competencies that are required to provide interdisciplinary team care to meet the wide spectrum of health care and service needs for veterans to provide leadership in interdisciplinary team delivery and training to other VA medical centers; and to provide role models for affiliated students in medical and associated health disciplines. Training includes the teaching of staff and students in the select VA priority areas of health care needs, e.g., geriatrics, ambulatory care, management, nutrition, etc.; instruction in team teaching and group process skills for clinical core staff; and clinical experiences in team care for affiliated education students with the core team serving as role models. During FY 1991, 179 students from a variety of health care disciplines were provided funding support at the 12 model ITTP sites.

Clinical Nurse Specialist

Clinical nurse training is another facet of VA education programming in geriatrics. The need for specially trained graduate level clinical nurse specialists is evidenced by the sophisticated level of care needed by the VA patient population, specifically in the area of geriatrics. Advanced nurse training is a high priority within the VA because of the shortage of such nursing specialists who are capable of assuming positions in specialized care and leadership.

The Clinical Nurse Specialist Program was established in 1981 to attract clinical specialists students to VA and to help meet requirement needs in the VA priority areas of geriatrics, rehabilitation, and psychiatric/mental health, all of which impact on the care of the elderly veteran. During FY 1988-89 the critical care pathway was added to the program. Direct funding support is provided to master's level nurse specialist student's for their clinical practicum at the VA medical centers that are affiliated with the academic institutions in which they are enrolled. In fiscal year 1991, 119 master's level clinical nurse specialist student positions were supported at 44 VA medical centers; 16 in geriatrics; 1 in rehabilitation; 31 in psychiatric mental/health; 23 in critical care; and 48 in adult health/med-surgery.

VA Gerontological Nurse Fellowship Program

Gerontological nursing has been a nursing specialty since the mid-1960's. As society changes, particularly in terms of the demographic trend in aging, more attention is being focused on both the area of gerontological nursing and the education of nurses in this specialty. Doctoral level nurse gerontologists are prepared for advanced clinical practice, teaching, research, administration, and policy formulation in adult development and aging.

Effective FY 1989-90, a 2-year nurse fellowship program become operational for registered nurses who are doctoral candidates enrolled in doctoral level programs, and whose doctoral dissertations have clinical research foci in geriatrics/gerontology. It is planned to select and fund two nurse fellows each fiscal year at approved VA medical center sites. Initial appointments will be for 1 year. Reappointments of 1 additional year are subject to satisfactory first year's performance evaluations. It is anticipated that a least half of the participants who complete this VA fellowship will be recruited into VA. For FY 1991 the three fellows who were provided funding support were appointed at VAMCs Ann Arbor, MI; Bedford, MA; and Lexington, KY.

Expansion for Associated Health in Geriatrics

A special priority for geriatric education and training is recognized in the allocation of associated health training positions and funding support to VA medical centers hosting GRECCs, and to VA Medical Centers (non-ITTG/GRECC sites) that offer specific educational and clinical programs for the care of older veterans. In FY 1991, a total of 170 associate health students received funding support at 64 VA facilities in the following disciplines: Social Work; Psychology; Audiology/Speech Pathology; Clinical Pharmacy; Clinical Nurse Specialist; and Occupational Therapy.

Continuing Education

In support of the VA's mission to provide health care to the aging veteran population, education and training continues to be offered to enhance VA medical center staff skills in the area of geriatrics. These educational activities are designed to respond to the needs of VA health care personnel throughout the entire Veterans Health Administration. Annually, Postgraduate and In-Service Training (PIT) funds are distributed to two levels of the organization for support of continuing education activities in priority areas.

First—Program 870 (Core PIT) funds are provided to each of the VA medical centers to meet the continuing education needs of its employees. VA Central Office also allocates funds for VAMC-initiated programs to allow health care facilities, with assistance from a Regional Medical Education Center (RMEC), to conduct education programs within the hospital to meet locally identified training needs. VAMC-initiated funds were used to support 22 separate activities specifically having geriatrics as the primary content.

Second—Continuing Education Field Units (CEFUs), which include seven Regional Medical Education Centers (RMECs), eight Cooperative Health Education Programs (CHEPs), two Dental Education Centers (DECs), and the Continuing Education Center (CEC) meet education needs by conducting programs at the regional and local medical center level. Examples of recent programs are:

- Clinical Issues in Caring for the Elderly
- Interdisciplinary Challenges in Caring for the Older Veteran
- Geriatric Dentistry
- Quality of Live Issues of the Elderly Veteran
- Rehabilitation of the Elderly
- Alzheimers Disease Diagnosis and Management
- Managing the Disturbed Elderly Patient
- Geriatric Assessment
- Gerontological Issues in the Domiciliary
- Elder Abuse

RMEC programs are also conducted in cooperation with the GRECCs, which received \$182,000 in PIT funds to support their identified needs. This collaborative effort ensures the efficient use of existing resources to meet the increasing demands for training in geriatrics/gerontology. For example, the GRECCs have met some of the training needs identified by RMECs and RMECs have utilized GRECC staff as faculty for their programs.

In response to a systemwide training need, a National Training Program was developed and implemented in fiscal year 1989. The program, "Health Care Problems of the Elderly," is a multiyear, multidisciplinary workshop which provided training to teams from facilities in Region 4 in FY 1991. A portion of the agenda was broadcast systemwide via satellite. Another multiyear National Training Program, "Alternatives to Acute Institutional Care," was presented to VAMC health care teams in Region 2 during FY 1991. "Ambulatory Care of the Elderly," another National Training Program, was expanded during the fiscal year to train teams from Regions 2, 3, and 4. Teams from Region 1 will receive training in FY 1992.

In addition, CORE PIT funds are provided to support continuing education experiences for the Geriatric Fellows and the Interdisciplinary Team Training Program staff members.

The Office of Academic Affairs worked cooperatively with the Office of Geriatrics and Extended care during the year on two new activities. One was the establishment of a Continuing Education Field Unit/Geriatric Research, Education and Clinical Center Geriatric Education Committee to develop continuity and organization in geriatric education for health care staff. FY 1991 activities of this committee were compiling and distributing a VA Geriatric Faculty Resource Directory and developing a long-range plan identifying training needs and how those needs would be addressed. The second activity was the formation of the Advisory Committee on Geriatric and Gerontology Education. This committee met to make long-range recommendations on the overall education and training programs for all disciplines, including trainees. Committee members included Geriatric experts from the private sector as well as the VA.

Health Professional Scholarship Program

The Scholarship program was established in 1980 and funded from 1982 through 1985 to assist in providing an adequate supply of nurses for the VA and the nation. In 1988 the Scholarship Program was reactivated to provide scholarships to students in full-time nursing and physical therapy baccalaureate and master degree programs in certain specialties specified by the VA. Since the beginning of the program, 58 awards have been given to students studying for advanced master's degrees in gerontological nursing. Of this number, 23 students have completed degrees and fulfilled their obligations by working as professionals in VA medical centers. fifteen of these professional nurses are still employed by VA. The remaining students are in the process of completing their degrees, and will be beginning their service obligations in the near future.

Learning Resources

The widespread education and training activities in geriatrics have generated a broad spectrum of requirements for learning resources throughout the VA system. Local library services performed hundreds of on-line searches on data bases such as AGELINE (available through Bibliographic Retrieval Services), and continue to add books, journals, and audiovisuals on topics related to geriatrics and aging. Multiple copies of several audiovisual programs were made available nationwide for VA staff use through the VA Network Audiovisual Delivery System.

VII. VETERANS BENEFITS ADMINISTRATION

COMPENSATION AND PENSION PROGRAMS

Disability and survivor benefits such as pension, compensation, and dependency and indemnity compensation administered by the Veterans Benefits Administration provide all, or part, of the income for 1,842,461 persons age 65 or older. This total includes 1,316,051 veterans, 498,019 surviving spouses, 24,812 mothers, and 3,679 fathers.

The Veterans' and Survivors' Pension Improvement Act of 1978, effective January 1, 1979, provided for a structured 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 acknowledgement of the special needs of our oldest veterans. The current amount added to the basic pension rate is \$1,673 as of December 1, 1991.

VETERANS ASSISTANCE SERVICE

Veterans Services Division personnel maintains liaison with nursing homes, senior citizens homes, and senior citizen centers in regional office areas. Locations are visited as the need arises. Appropriate pamphlets and application forms are provided to personnel at these homes during visits and through frequent use of regular mailings. State and Area Agencies on Aging have been identified and are provided information on Department of Veterans Affairs (VA) benefits and services through workshops and training sessions. Seminars are conducted for nursing home operators and other service providers that assist and service this patient population. Regional Office coordinators continue to serve on local and State task forces that deal extensively with the problems of the elderly.

The Veterans Assistance Services exhibit, "Veterans Benefits for Older Americans," highlights, by pictures and accompanying text, the various benefits explained in the pamphlet of the same title (VA Pamphlet 27-8-2). The exhibit, designed to convey VA's concern with the aging veteran populations, has been displayed extensively at meetings addressing problems of aging. The pamphlet has been given wide distribution by information and referral representatives at field stations.

The elderly as a group encounter problems with transportation due to rising costs, limited income, and most importantly, physical ailments. Thus, Veterans Assistance Service continues to emphasize the use of the toll-free telephone service as a means of contacting their offices for information and assistance.

A special listing of aged beneficiaries has been furnished to regional office Veterans Service Divisions for individualized outreach use. Veterans and/or dependents are being contacted and provided with information and claims assistance on any additional VA benefits that may be applicable to them. One of the reasons for this outreach program is our concern that large numbers of our older population are "at risk" and, as such, they may be unaware of the higher income limitations available under the pension program, i.e., housebound status and aid and attendance. Moreover, we are convinced that many are unaware of the impact of unreimbursed medical expenses on pension eligibility and the change in the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, regarding a veteran, without dependents, who is eligible for medicaid and is in a medicaid approved nursing home that may not receive pension in excess of \$90 monthly.

An up-dated roster of World War I veterans receiving compensation or pension has been requested and will be furnished to field stations during the first quarter of fiscal year 1992 for use in their outreach to the elderly programs.